Section 300 Table of Contents Coverage Groups

- **300.1** Introduction—Coverage Groups
- 300.2 Medicaid Categorically Needy (CN) Coverage
- 300.3 Medicaid Medically Needy (MN) Coverage
- **300.4** Coverage Group Tracks
 - (a) Family and Children Coverage Groups (FAC) (F-Track)
 - (b) Pregnant Women (c) Maryland Children's Health Program (MCHP) (P-Track) MCHP Premium (D-Track)
 - (d) Foster Care & Subsidized Adoptions (E-Track)
 - (e) Refugees (G-Track)
 - (f) X02 Undocumented or Unqualified Immigrants- Emergency Medical Services
 - (g) Aged, Blind, or Disabled (ABD) (S-Track) or Children or Adults in Long Term Care ((T-Track)

Attachment A (Local Department of Social Service Contact List)

Attachment B (Local Health Department Contact List)

(h) Women's Breast and Cervical Cancer Health Program (WBCCHP)

Attachment A- WBCCHP Coordinators Contact List

- (i) Qualified Medicare Beneficiaries (QMB)
- (i) Dually Eligible Persons
- (k) Specified Low-Income Medicare Beneficiaries (SLMB)

Attachment A- 2012 Dual Eligible Standards

- (I) Disabled Adult Children (DAC)
- (m) Disabled Widowed Beneficiaries (DWB)
- (n) Qualified Disabled and Working Individuals (QDWI) Coverage Group (S06)
- (o) Family Planning Program
- (**p**) Children and Temporary Cash Assistance (TCA) adults in Long-Term Care Facilities (LTCF)

300.5 Pickle Amendment

Frequently Asked Questions (FAQs) and Answers

Objectives for Section 300

- 1. Define frequently used coverage groups;
- 2. Define Pickle Amendment;
- **3.** How to apply and the eligibility criteria for each group.

300.1 Introduction-Coverage Groups

A <u>coverage group</u> is a group of people who meet specific criteria to receive Medical Assistance (also known as Medicaid or MA) or other benefits through Maryland's Medical Care Programs. Sometimes the only difference between coverage groups is a single criterion.

For example, children under the age of one are in one group, while those between one and six years of age are in another. Families whose income is within the medically needy income limit are in one group and those with income exceeding the limit (spend-downs) are in another. Consequently, there are many different coverage group codes to describe how recipients qualify for benefits.

How many coverage group codes?

There are 68 coverage group codes in the Maintenance Management Information System (MMIS-II). Each coverage group is identified by a code; one letter designating the "track," followed by two numbers (e.g., F01).

Some coverage group codes are assigned to recipients by a database program; Client Automated Resource and Eligibility System (CARES), as part of an eligibility determination that is used by Department of Health and Mental Hygiene (DHMH) and Department of Human Resources (DHR).

Other codes originate within DHMH in order to identify recipients enrolled in programs that are not included in CARES. Generally, Case Manager (CM) does not need to know all 68 coverage groups but should be familiar with the tracks

300.2 Medicaid Categorically Needy (CN) Coverage

Definition:

The federally matched Medicaid (Title XIX) and CHIP (Title XXI) programs provide the broadest scope of medical coverage. Persons may be eligible for Categorically Needy (CN) only or may also be eligible for cash benefits under the Supplemental Security Income (SSI) or Temporary Assistance for Needy Families (TANF) programs. CN includes full scope coverage for Pregnant Women (PW), children, the aged, blind, and persons with disabilities.

Coverage Group:

• The following persons are eligible without having to file a separate application and are

Covered as Categorically:

- A person receiving Temporary Cash Assistance (TCA), SSI, Mandatory State Supplement, or Optional State Supplement.
- A Pregnant Woman who has been denied TCA solely because she is not in her last trimester of pregnancy.
- A family which has been denied TCA solely because the amount of the payment would be less than \$10.
- A Family terminated from TCA because of increased earnings or hours of employment:
 - a) If a family loses TCA solely because of increased income from employment or increased hours of employment, MA shall be provided to all members of the family for a 4 month period if:
 - 1) The family received TCA in three or more months of the sixmonth period immediately preceding the month in which it became ineligible for TCA; and
 - 2) At least one, but not necessarily the same member of the family is employed throughout the 4 month period
 - b) The 12 month period begins with the first month of TCA ineligibility.
- The following persons shall apply for MA and, if determined eligible, are covered as CN:
 - A person who is eligible for TCA, SSI, or Optional State Supplement benefits except for a requirement of those programs that is specifically prohibited under Title XIX.
 - o A person who:
 - In August, 1972, was entitled to Social Security Assistance, Survivors, and Disability

Insurance, and:

- 1) Was receiving TCA, Social Security, Aid to the Permanently and Totally Disabled, or Public Assistance to the Needy Blind;
- 2) Was not receiving TCA, Social Security, Aid to the Permanently and Totally Disabled, or Public Assistance to the Needy Blind but would have been eligible if he had applied; or
- 3) Would have been eligible for TCA, Social Security, Aid to the Permanent and Totally Disabled, or Public Assistance to the Needy Blind if he/she was not in a medical institution or intermediate care facility.

Eligibility Criteria:

- Children under age six whose family income is below 133% of the Federal Poverty Level (FPL);
- Pregnant Woman whose family income is below 250% of the FPL (services are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care);
- SSI recipients in most States;
- Recipients of adoption or foster care assistance under Title IV of the Social Security Act; or
- Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time)

300.3 Medicaid Medically Needy (MN) Coverage

Medically Needy (MN) is a federal and state funded Medicaid program for persons who are aged, blind, or with a disability; pregnant women; or children with income above CN limits. MN provides slightly less medical coverage than CN, and requires greater financial participation by the customer.

Coverage Groups:

The following persons who apply for and meet the requirements of these regulations are covered as MN:

- A Pregnant Woman who has been denied TCA solely because her income or resources exceed the cash assistance level;
- A person younger than 21 years old;
- A caretaker relative (and spouse);
- An aged, blind, or disabled person; and
- A person who was eligible as MN in December, 1973, on the basis of the blindness or disability criteria of aid to the Permanently and Totally Disabled or Public Assistance to the Needy Blind and who continues to meet current requirements except for blindness or disability criteria.

Eligibility Criteria:

The household's income is used to determine if they meet the standards for medically needy.

• If your assets are no more than the MN limits, but income exceeds the MN standard, you may "spend-down" to qualify for Medicaid coverage during a six-month period. The difference between the amount of your income and the eligibility standard is called excess income. Under the spend-down process, your application will remain in preserve until the end of the six-month period. If during that time you incur medical expenses, the amount of your medical bills can be deducted from your excess income.

If you meet your excess income amount within the six-month period, you may be determined eligible for Medicaid for the remainder of the six-month period.

• To qualify for Medicaid as "MN", your assets (i.e. resources) must be no more than the cap for your household size (e.g. \$2,500 for a household of one person). There is no spend-down process for assets. If a person or household is asset over-scale as of the first day of the month, the person or household is ineligible for the entire month. The individual or household will remain ineligible until the assets are reduced to below the MN limit through allowable means (such as daily living expenses or paying down expenses). The individual or household may then reapply for Medicaid. If the assets are transferred or disposed for less than full value within 60 months before applying for Medicaid, there may be a penalty of ineligibility for Long Term Care (LTC) or waiver applicants.

300.4 Coverage Group Tracks

A track is a group of related coverage groups. Currently there are 11 tracks. The same eligibility rules are used for all coverage groups in the same track.

The most commonly used tracks are used below:

- Families and Children (FAC) (**F-Track**)
- Children placed in foster care or subsidized adoptions (**E-Track**)
- Low income pregnant women and children in the Maryland Children's Health Program (MCHP) (P-track)
- Uninsured children under the age of 19 whose income is above 200% but below 300% of the Federal Poverty Level. (MCHP Premium) (**D-Track**)
- Aged, blind, or disabled individuals (ABD) (S-Track)
- Refugees (G-Track)
- Aliens (**X02**) Undocumented or Unqualified Immigrants
- LTC cases have their own tracks,
 - ABD individuals (**L-track**)
 - Children and TCA adults and Family LTC (**T-track**).
- FAC LTC spend-down group (**T99**). Note: This is for a child in LTC, who has monthly income so high that it exceeds the LTC facility's cost of care, and places the child in spend-down. While this rarely occurs, the group is needed because it is covered under the State Plan.

Knowing the basic requirements for each track enables the user to quickly understand a recipient's enrollment in a particular coverage group.

(a) Family and Children Coverage Groups (FAC) (F-Track)

FAC are low income families with dependent children or other eligible children under the age of 21 who meet the financial and technical eligibility requirements for the State's TCA Program, which replaced Aid to Families with Dependent Children (AFDC) effective October 1, 1996 are automatically eligible for Medicaid. Families consist of parent(s) (biological, step or adoptive) or other caretaker relatives and unmarried children living with them). An eligible pregnant woman also constitutes family, low-income families, or children.

Medicaid may also be granted to families or individuals who would qualify for TCA benefits but did not apply, or who lost their TCA eligibility for one of the following reasons:

- Increased earnings or hours of employment;
- Loss of earned income disregards;
- Increased child support collections;
- Non-compliance with TCA work requirements; or
- Failing to meet another TCA non-financial requirement.

Where to apply

- A customer may apply at their local department of social services (LDSS) (see Attachment A);
- A customer may apply at local health department (LHD) if they are applying for a child, family and children, or if pregnant or online at;
- www.Marylandsail.org.

Eligibility Criteria

- Household includes a child under 21 years of age;
- Income that is below the Medically Needy Income Level (MNIL) for your household size; (Household may be eligible if the medical expenses that are owed are very high. This is called a "spend-down").
- Able to provide proof of citizenship and identity <u>or</u> provide proof of Legal Permanent Residency.

Voluntary Withdrawal

- An individual who has filed an application may voluntarily withdraw that application at any time. In this event, the application will remain the property of the LHD or LDSS.
- When an application is voluntarily withdrawn, customers may come back within the consideration period to reapply with their original application. This will prevent the CM from doing retro.

Application Denial

When an application is denied, a new application may be filed the following month.

(b) Pregnant Women, (c) Maryland Children's Health Program (MCHP) (P-Track) MCHP Premium (D-Track)

The Maryland Children's Health Program (MCHP) gives full health benefits for children up to age 19 who are enrolled in D04 if their parent or caretaker relative is willing to pay the P-Track and MCHP monthly premium and if their household income is above \$250% and at or below 300% of the FPL. In addition it covers Pregnant Women of any age who meets the income guidelines. MCHP enrollees obtain care from a variety of Managed Care Organizations (MCOs) through the Maryland Health Choice Program. The certification period for a child in MCHP is 12 months. Redeterminations for MCHP and MCHP Premium cases will be mailed every 12 months with the exception of Pregnant Women cases. There are no redeterminations for Pregnant Women since pregnancy status is not continuous.

MCHP Eligibility Criteria

An applicant must meet both technical and financial eligibility criteria for MCHP.

- Technical factors include permanent Maryland resident or (intent to stay), citizenship and identity or qualifying immigration status. Immigrants whose immigration status does not qualify them for full coverage may be eligible for services received to treat an emergency condition;
- As a condition for eligibility, the applicant (child or Pregnant Woman) must provide the LDSS or LHD with their Social Security number;
- Eligibility cannot be denied, delayed or discontinued pending the issuance of the Social Security number;
- Social Security numbers can be verified through the State Verification and Exchange System (SVES);
- Financial eligibility: family income is within income standards for the size of the family. Income standards are based on the FPL and change annually. Income of a Care Taker Relative Other than Parent (CTROP) is not counted when determining financial eligibility;
- To be eligible, children must be under age 19 and have a family income at or below 200% of the FPL for free coverage in MCHP;
- To be eligible as a Pregnant Woman, the woman of ANY AGE must be pregnant or in the first or second postpartum month and have family income at or below 250% of the FPL;
- Resource consideration is not considered when determining MCHP eligibility.

Application

- A person who wishes to apply for MCHP must submit a signed application form or Eligibility Determination Document (DHR/FIA 9701) to their LHD/LDSS or
- Apply online at www.marylandsail.org

- The applicant may be assisted by the person of their choice including the local department staff.
- The date of application is the date on which a signed application form is received by the local department (mailed or hand delivered).
- Regarding processing application time limitations for the LHD, a decision shall be made promptly, but no later than 10 days from the date of application. As for the LDSS, a decision shall be made promptly, but not later than 30 days from the date of application.
- The certification period for a child in MCHP is 12 months.

Redetermination

Redeterminations for MCHP cases will be mailed every 12 months with the exception of pregnant women cases. There are no redeterminations for pregnant women since pregnancy status is not continuous.

Voluntary Withdrawal

- An individual who has filed an application may voluntarily withdraw that application at any time. In this event, the application will remain the property of the LHD or LDSS.
- When an application is withdrawn, a new application may be filed the following month and a new period under consideration is established.

Application Denied

When an application is denied, a new application may be filed the following month.

(d) Foster Care & Subsidized Adoptions (E-Track)

The Title IV-E foster care and subsidized adoption program was created by U.S. Public Law 96-272 as set forth in Title IV, Part E of the Social Security Act. The purpose of Title IV-E foster care program is to prevent the unnecessary placement of children from low-income families by offering states fiscal incentives for providing preventive services. The purpose of Title IV-E subsidized adoptions program is to ensure that "Special Needs" children who are difficult to place in adoptive homes do not remain in foster care solely for financial reasons.

In Maryland, "Special Needs" is defined as any one of the following:

- Age six or older after November 1984 or two years old prior to November 1984;
- A member of a minority race;
- A member of a sibling group;
- Physically or mentally handicapped or emotionally disturbed;
- A child with a high risk of physical or mental disease.

The Centers for Medicare and Medicaid Services (CMS) approved changes in MA eligibility requirements for E-track children in out-of-home placements. Income and resources are no longer a factor of MA eligibility for foster care or subsidized adoption children in the E-track. Therefore, the only reason for a foster care child to be MA eligible in the State-only coverage group of E03 is if the child fails a technical factor of MA eligibility, such as citizenship or Social Security number (SSN). Non-IV-E eligible children in State subsidized adoptions are eligible in the federal category of E02 if they meet MA technical eligibility requirements and have special needs for medical, mental health, or rehabilitative care. E01 is for IV-E or SSI eligible foster care or subsidized adoption children. E02 is for non-IV-E foster care children or special needs subsidized adoption children who are not IV-E or SSI eligible, but meet the MA technical eligibility requirements. The State-only category of E04 is for all other children in State subsidized adoptions.

When the state places a child in foster care or subsidized adoption, it is imperative that the MA certification process is timely so that the child has immediate access to health care coverage. If there are unpaid medical bills for the child, retroactive eligibility should be determined for the three months prior to the date of MA E-track application. Good communication between the OHP service worker, FIA MA case manager, and IV-E specialist (who determines IV-E eligibility) at the LDSS is necessary to ensure prompt and correct MA coverage. This information provides uniform procedures to be followed by all local offices when processing E-track MA applications filed on behalf of a child in Out of Home Placement (OHP) (IV-E or State foster care and subsidized adoptions) when:

- The child is filing an initial MA-application and is not already active or pending in CARES for MA and/or other eligibility; or
- The child applicant is already a recipient in an active or pending Assistance Unit (AU), such as TCA, Food Stamps (FS), SSI, MA, or the Maryland MCHP.

Eligibility for OHP is established by the DHR regulations found in COMAR 07.02.11. Federal funding of OHP services is governed by Title IV-E of the Social Security Act (SSA).

The E-track is only for foster care children committed by the courts to the custody of the DHR and for children receiving subsidized adoption services from DHR. The MA application for a foster care child must clearly indicate if parental rights have been terminated, because this triggers a child support referral. The procedures in this section are not applicable to children placed in foster care or adoption by private agencies or individuals, who should have their eligibility determined under the appropriate MA or MCHP coverage group other than the E-track. They are not eligible in the E-track. However, the E-track may include children who are dually committed to the custody of DHR and the Department of Juvenile Services (DJS), so long as the child is receiving foster care or subsidized services from DHR.

As long as children in the Kinship Care Subsidized Guardianship Waiver Program remain under the State's custody, they stay MA eligible in their E-track coverage group. Once guardianship is granted and the service case is closed, children in the Kinship Care Subsidized Guardianship Waiver Program must have their eligibility determined in the appropriate MA or MCHP coverage group other than the E-track. They are no longer eligible in the E-track. FIA Action

Transmittal 01-02 dated 8/7/2000 addresses how to redetermine eligibility when the guardianship through the Kinship Care Program goes into effect for children previously certified in the Etrack.

Coverage Groups in the E-track for Children in State Out-of-Home Placements (Foster Care) or in Subsidized Adoptions.

Note: The MA CM should not test for income or resources for any of the coverage groups in the E-track as a condition of MA eligibility, but should still test for technical MA eligibility. The MA CM should enter \$1 for the foster care or subsidized adoption income and enter any child support, SSI, or SSDI income with a valid value of "ON" ("other non-countable"). The MA CM should narrate for each type of non-countable income that is entered and for any other of the child's reported income or resources of the child that are not counted for the E-track eligibility determination, but may be needed for a future application.

Following is a description of the basic MA eligibility requirements for each coverage group in the E-track:

• E01: IV-E or SSI Children in Foster Care or Subsidized Adoption

Federally matched MA is automatically provided, without a separate test for MA eligibility, to any child receiving adoption for foster care benefits who is either eligible under Title IV-E of the Social Security Act or SSI-eligible. Since CARES has little programming for E01, a case should only be pended in E01 if the MA CM confirms (through SVES, SDX, or SOLQ) that the child is receiving SSI benefits or if IV-E eligibility is confirmed by the LDSS IV-E specialist, not based on a presumption of SSI or IV-E eligibility.

- o If it is later found that an E02, E03, or E04 child is IV-E or SSI eligible, the MA CM should "J" Screen an existing E01 assistance unit (AU) or use "Add-A-Program" to establish an AU for the E01 coverage effective as of the 1st day of the month after the MA CM is notified of the IV-E or SSI eligibility. If a previous E01 AU is available, the MA CM could "J" Screen an existing E01 AU, if one was previously available.
- OHP children who receive SSI are included in E01, rather than in the S02 Coverage group, even if they are not IV-E eligible. However, since CARES is programmed to deny an E01 application with SSI ("SI") income, the Child's SSI income should be entered on the CARES UINC Screen with a valid value of "ON" for other non-countable income. The MA CM should fully narrate in CARES.
- E02: Non-IV-E Foster Care and Special Needs Subsidized Adoption

Federally matched MA is provided to foster care children who are not IV-E eligible but who do meet the MA technical eligibility criteria at COMAR 10.09.24.05 (Chapter V of the Medicaid Eligibility Manual), including the MA citizenship requirements. Non-IV-E children also qualify for E02 if they are receiving

subsidized adoption services through the DHR, have special needs for medical, mental health, or rehabilitative care, and meet the MA technical eligibility requirements. Since CARES is programmed to apply the same medically needy financial rules for this group as for F98, the MA CM must assure that CARES does not deny an eligible OHP case for E02 due to failing financial eligibility criteria (see Section II).

- E03: State Funded Foster Care
 The State funds full MA coverage for foster care children who are not federally eligible for E01 or E02.
 - Since CARES does not trickle properly to E03 from E01 or E02, the MA case manager should use "Add-A-Program" or "J" Screen an existing E03 AU and complete the eligibility process for an E03 AU if a foster care child is ineligible for E01 or E02. The MA CM must assure that a foster care child is in the appropriate coverage group, and is only in E03 if MA technical eligibility criteria are not met (e.g. SSN, citizenship).
 - If it is later determined that the child is IV-E or SSI eligible, the MA CM should "Add-A-Program" or "J" Screen an existing E01 AU and complete the eligibility process for an E01 AU.
 - o If verifications later confirm that the non-IV-E foster care child meets the MA technical eligibility criteria in COMAR 10.09.24.05 (including citizenship requirements), the MA CM should "Add-A-Program" or "J" Screen an existing E02 AU and complete the eligibility process for an E02 AU.

• E04 State Funded Subsidized Adoption

The State funds full MA coverage for children in State subsidized adoptions who are not federally eligible for E01 or E02.

- Since CARES does not trickle properly to E04 from E01 or E02, the MA CM should "Add-A-Program" or "J" Screen an existing E04 AU and complete the eligibility process for a E04 AU if a subsidized adoption child is ineligible for E01 or E02.
- o If it is later determined that the child is IV-E or SSI eligible, the MA CM should "Add-A-Program" or "J" Screen an existing E01 AU and complete the eligibility process for an E01 AU.
- o If verifications later confirm that the non-IV E subsidized adoptions child with special medical needs meets the MA technical eligibility criteria in COMAR 10.09.24.05 (including citizenship requirements), the MA CM should "Add-A-Program" or "J" Screen an existing E02 AU and complete the eligibility process for an E02 AU.

CARES Procedures Followed by MA CM for MA Eligibility Determinations in the E-Track

(A) Notification by the Service Worker and IV-E Specialist

A service unit (SU), which shows the type of service for the child, is created for each child concerning foster care, kinship care, or subsidized adoption. This is based on the demographics, service information, and proper enumeration provided by the service worker. Either the existing Client ID is matched or, if there is no existing Client ID, a new one is created for the child.

- The service worker promptly advises the FIA MA CM of a child in foster care or subsidized adoption who needs to be certified for E-track OHP MA eligibility. The MA CM is also informed if retroactive eligibility should be determined based on the child's living circumstances prior to the OHP application month (e.g., newborn abandoned in hospital, child living with parent(s) or caretaker relative, child in LTC facility for less than a full calendar month).
- The service worker acts as the child's representative for purposes of filing the MA application. The service worker must provide all available information and verifications requested by the MA CM, including related to retroactive eligibility and unpaid medical bills.
- The IV-E specialist provides information to the MA CM about the child's IV-E eligibility. The MA eligibility determination should not be delayed by the IV-E determination. If the child meets technical eligibility for MA and the IV-E specialist has not yet determined IV-E eligibility when the MA application is being processed and finalized, the MA CM should PEND the application under Medical Coverage group E02 and complete the eligibility determination process. If the child is later determined to be IV-E eligible, the MA CM should "Add-A-Program" or "J" Screen an existing E01 AU and complete the eligibility process for an E01 AU as of the 1st of the month after the MA CM is notified by the IV-E specialist.

(B) Screening and Pending the MA Case

When the MA CM is notified by the service worker of a foster care or subsidized adoption child requiring an OHP MA eligibility determination:

• Perform an inquiry in CARES to research and determine if the child is a member of another AU as active, pending, closed or denied. Because the service AU has already been opened by the service worker, these cases should already be known to CIS, and a match should be made to the client on the database. Make every effort to screen the child for an existing Client ID to prevent assigning multiple IDs. If more than one ID exists, refer to CARES Bulletin 98-17, Multiple Client IDs, for how to close the duplicate ID.

Note: When a child is adopted, there is actually a break with the old AU and Client ID number. The child may get a new Social Security number (SSN), also. Only if a complete break is not intended for the adopted child would the old SSN, AU, and Client ID be linked on CARES with the new identifiers.

- Screen the child in the appropriate E-track coverage group, using Option "J" on the AMEN Screen in CARES.
 - o Use E01 only if it is confirmed that the child is IV-E or SSI eligible.
 - Use E02 for all other foster care or subsidized adoption placements.
 - CARES does not trickle properly from E01 or E02 to E03 or E04. Therefore, "Add-A-Program" or "J" Screen an existing AU for E03 if a foster care child is not eligible for E01 or E02. For a subsidized adoption child, "Add-A-Program" or "J" Screen an existing AU for E04 if the child is not eligible for E01 or E02.

For instance, in option "J" screening for E02, use income type: SF-State subsidized Foster Care and include \$1 as the payment amount on the CIRC screen.

(C) Interview

After properly screening and pending the child in the appropriate E-track MA coverage group, select option "O" to complete the "Interview" process on CARES. The MA CM should never bypass this step. Option "O" is necessary because the CARES system performs a "copy back" function of information between the ongoing month and the processing months.

- 1. An "interview" is conducted between the service worker and the MA CM through a paper application rather than face-to-face interview. The DHR/FIA CARES 9708 is used as the MA application. The MA CM is responsible for establishing and maintaining the MA case record. The MA CM enters the information into CARES for the E-track MA AU created during the "J" screening process.
- 2. For the E-track AU, be sure to enter the child's appropriate living arrangement code on the **DEM1** screen.
 - o If the child is either IV-E or SSI eligible, enter the living arrangement as: "SE" Subsidized Adoption, IV-E.
 - o If the child is neither IV-E nor SSI eligible, enter the living arrangement as: "FC" Foster Care, Non IV-E; or "SA" State Subsidized Adoption, Non IV-E.
 - o Do not use the valid value "AH", At Home, for children placed in foster care or State subsidized adoption.
 - o Complete all the necessary information to include Parental Status and the correlating **Absent Parent** screens, when applicable.
 - Use caution when processing Subsidized Adoption cases, because absent parent information is not necessary.
- 3. If there is an active AU with the child as a member in another program (e.g., TCA, FS), contact the Worker of Record for the TCA/FS/MA/MCHP case to request that the child be removed from the existing AU as of the end of the current month. The entire AU may need to be closed if there are no remaining TCA eligible children. If the child is removed from the existing AU

historically to the beginning of the month of OHP, the family may have to repay TCA and/or FS assistance received on the child's behalf for that month.

- o If the child is active for MA in the month of OHP as a member of a TCA, MA, MCHP, and/or FS AU, change the living arrangement to "NO" on the child's DEM1 screen for the ongoing month. This includes SSI-eligible children. If the child is an active SSI AU (S02), the child's S02 AU must be closed then immediately processed under the E01 eligibility, in order to indicate foster care/subsidized adoption eligibility and to take advantage of the special HealthChoice rules and assistance for E-track children.
- o If the child is a member of a pending TCA, MA and/or MCHP AU in the month of OHP, make the living arrangement change effective the month of placement.
- o If the child is an active or pending FS-only AU in the month of OHP, change the living arrangement for the ongoing month.
- For any of the above instances, two narrations must be completed on CARES. Narrate on the TCA, FS, or MA NARR screen from which the child is being removed, as well as the NARR screen of the E-track MA eligibility case.

If this is an initial MA application for a child who does not have an existing active or pending TCA, MA, MCHP, and/or FS AU, pend the appropriate E-track coverage, narrate, and determine eligibility as of the month of OHP.

- 4. Determine MA eligibility in the appropriate E-track coverage group, as follows:
 - Finalize MA eligibility as soon as possible (within the 30-day time Limitations), for either the current month or the ongoing month (see #3 above), even if the child support or IV-E eligibility information is not yet available. The child support information may be added later to the CARES screens when it becomes available. Any income from child support must be coded as "ON" so it will not affect the child's MA eligibility.
 - If the child is SSI-eligible or confirmed as IV-E eligible by the IV-E specialist, the MA CM should finalize the case in E01, including closing an SSI-eligible child in S02.
 - If the child is not eligible for IV-E or SSI or the IV-E specialist has not determined IV-E eligibility by the time that the MA CM finalizes the case, the MA CM should determine eligibility in E02.
 - If the child is not eligible for E01 and E02, the MA CM should "Add-A-Program" or "J" Screen an existing AU for the State-only category of:
 - o E03 if the child is receiving foster care assistance; or
 - o E04 if the child is receiving subsidized adoption services.

- 5. For the E-track AU, enter on CARES the appropriate address. The authorized representative screen is optional, but may also be completed.
 - For a foster care AU:
 - On the ADDR screen, enter the LDSS address as the residential address, as well as the service worker information as dictated by your agency. The service worker will receive the MA card, HealthChoice enrollment materials (if E01 or E02), and all eligibility services.
 - For a subsidized adoption AU:
 - On the ADDR screen, enter the child's adoptive home as the residential address.
 - Optional: On the AUTH REP screen, enter the adoptive parent as Authorized Representative, type "R2", so that the adoptive parent will receive the MA card, HealthChoice enrollment materials (if E01 or E02), and all eligibility notices.
- 6. Presently, CARES requires that any child in the E-track have either foster care or State subsidized adoption income. Due to this requirement, enter \$1.00 on the UINC screen for such unearned income.
 - o Use income type "FC", "DA" or "DD" for coverage group E01.
 - o Use income type "SF" for E02 or E03.
 - o Use income type "SS" for E02 or E04.

Since income and resources are no longer a factor of MA eligibility for the E-track, enter no other countable income or resources for the child. Enter any child support, SSI, or SSDI income with a valid value of "ON" for other non-countable income, and fully narrate on both the NARR screen and the Remarks screen about the child's income and resources, which may be needed for a future application.

• CARES will deny any E-track AU once SSI ("SI") income is entered. Therefore, to change the coverage group of an SSI child from S02 to E01, the amount of SSI income must be coded as "ON" (other non-countable income) on the UINC screen. In addition, \$1 of foster care income must be entered on the UINC screen to ensure the child's technical eligibility on CARES for E01. Code the \$1 income as "FC" (IV-E foster care) and process the case.

Follow these procedures until you are notified that CARES has been modified.

(**D**) Processing and Finalizing the Eligibility Determination

Select options "P" Process and "Q" Finalize. Note that the eligibility tests for the E-track are different than the tests performed in other MA tracks, to facilitate prompt eligibility determinations.

- 1. For E01, there are virtually no eligibility tests on CARES for MA eligibility. For that reason, a child must not be screened in this coverage group unless the child is confirmed as SSI or IV-E eligible. A child screened in this coverage group will not fail MA eligibility, but will be certified as federally eligible, if processed correctly with the correct corresponding valid values. Until modifications are made to CARES for E-track coverage groups, trickling should not occur.
- 2. For E02, CARES applies the same eligibility tests as for the FAC MN category F98, which are no longer applicable for E-track eligibility. This is why countable resources and income should not be entered for E02, except for \$1 of foster care or subsidized adoption income. The MA CM must assure that CARES does not deny an E02 AU for financial eligibility reasons. If CARES denies an E02 AU for MA technical eligibility reasons (e.g. SSN, citizenship), the MA CM should "Add A Program" or "J" Screen an existing AU for a State-only E03 AU for a foster care case or E04 AU for a subsidized adoption case.
- 3. If retroactive MA eligibility (for at most three months period to the month of E-track application) is requested due to the child's unpaid medical bills, the MA CM must obtain information from the OHP service worker about the child's living arrangements prior to the OHP application month. The coverage group used for determining retroactive eligibility is based on those living arrangements and other factors related to eligibility.
- **4.** It is imperative that a child placed in foster care or subsidized adoption is certified as promptly as possible, and that there is no lapse of coverage when a child is removed from another AU to be opened in an E-track coverage group.
 - a. It is optimal to remove the child from an active AU on one day and then to open eligibility in an E-Track coverage on the following day, since two transactions (close/open) do not read over to MMIS through the interface on the same day. <u>Check MMIS</u> to make sure that the transactions took effect.
 - b. All E-Track applications must be finalized as soon as practicable, with or without complete verifications.
 - o If the IV-E eligibility has not yet been determined by the IV-E specialist, finalize the case in E02. If the child is not eligible for E02 due to MA technical eligibility requirements (e.g. verifications, SSN, citizenship), "Add-A-Program" or "J" Screen an existing AU for the State-only category of E03 for a foster care case or E04 for a subsidized adoption case.
 - o If there are any outstanding verifications, use the valid value of "OT" for "Other" so the E03 or E04 AU will process within the 30-day timeframe.
 - o Create a 745 alert to check on requested or outstanding verifications within a month if the child was not eligible for:
 - o E01 because the IV-E specialist has not yet determined IV-E eligibility; or
 - o E02 due to lack of verifications related to technical MA eligibility (e.g., SSN, citizenship).

c. If verification is later received that will enable certification in the federally matched coverage group, do "Add-A-Program" or "J" Screen an existing AU, close the original AU, and certify the child in either E01 (for SSI or IV-E foster care of subsidized adoptions) or E02 (for non-IV-E federally-eligible foster care or special needs subsidized adoption).

(E) Post Eligibility Activity

Once the MA eligibility is certified on CARES, there is an overnight electronic transfer of the MA date from CARES to MMIS at DHMH. There is also an electronic transfer of absent parent data from CARES to the DHR Child Support Enforcement Administration. The service worker provides information about the absent parents for establishment of child support via the Eligibility Determination Document (EDD) from CARES or the CARES 9708 application form, during the processing of the OHP MA eligibility for foster care cases.

If the child was not already MA eligible, DHMH issues the MA card and sends it to the service worker/unit for a foster care child or to the adoptive parent. If the child was already MA eligible, the MA CM should process a request for a duplicate MA card, to assure that the service worker or adoptive parent has the child's MA card. The request should be entered the day after the E-track MA eligibility is committed to CARES, using the following CARES procedures:

- From the CARES Main Menu, select option "L- Financial Mgmt Misc."
- On "LMEN" selection option "S- MA Card Reissuance" and enter the Client ID.
- On the "MACR" (MA Card Reissuance) Screen, verify information and select "Y" in the "Reissue Another Card" field. Press Enter to commit the request.
- CARES will return to "LMEN" with a message of "Insert Successful".
- Update case narrative to reflect duplicate card request.

Children certified in E01 or E02 are eligible for HealthChoice.

- If the child is already enrolled in HealthChoice, the child remains with the same Managed Care Organization (MCO) and primary care provider (PCP) when the child's coverage group changes to the E-track. The child's representative should follow HealthChoice procedures to request a different MCO and/or PCP, if necessary.
- If the child is not currently enrolled in HealthChoice but was enrolled within the past 120 days, the child is auto-assigned to the previous MCO. The representative may request a change of MCO and/or PCP if necessary.
- If the child is neither currently enrolled in HealthChoice nor enrolled within the past 120 days, the enrollment broker will send the HealthChoice packet to the representative for selection of an MCO.

Children eligible in the State-only coverage groups of E03 and E04 are not enrolled in HealthChoice, but receive the full range of MA covered services on a fee-for-service basis. However, because they are not HealthChoice eligible, they may not be enrolled in the Rare and Expensive Case Management (REM) program.

Since CARES does not schedule an annual redetermination for an active E01 AU, the MA CM should set a 745 Alert to review the case at least every 12 months or sooner if the child is turning 21 within a year. Then, the MA CM must verify with the IV-E specialist that the IV-E eligibility continues and verify with the OHP service worker that the OHP service case is still open.

NOTE: ALL CASE ACTIVITIES MUST BE FULLY NARRATED IN CARES.

Children Discharged from Out-of-Home Placements- Unscheduled Redetermination Eligibility Policies and CARES Procedures

I. Overview

Federal and State regulations provide for the prompt redetermination of MA or Medicaid eligibility when there is a change in an individual's circumstances (e.g. living arrangements, income, and resources) that may result in the loss of or change in eligibility. Federal and State guidelines also stipulate that MA eligibility must continue until it has been determined that an individual no longer meets the criteria for continued eligibility.

This information in this section sets forth policies and procedures, effective upon receipt, which is to be followed to facilitate the transition when a court rescinds a child's commitment to the State's custody and the child is discharged from an out-of-home placement (OHP). Each LDSS identifies which MA CM is responsible for implementing these policies and procedures. These procedures ensure that these children will continue to receive health care benefits, without a lapse in MA coverage, until they have been given the opportunity to reestablish continued eligibility under MA community or LTC or the Maryland Children's Health Program (MCHP).

When a child is discharged from the OHP, the service worker at the LDSS is to give the child's parent or representative the child's Medical Care Program identification card, so the child may access MA services while the child's eligibility is being redetermined. If the child is enrolled in HealthChoice, the service worker is to inform the parent/representative of the child's MCO and PCP, and give the parent/ representative the child's MCO card. The MCO should then be provided with updated contact information about the child's head of household or emergency contact.

Note: Scheduled redeterminations are required at least every 12 months for coverage groups E02, E03, and E04. Also, continued IV-E certification must be verified with LDSS's IV-E specialist at least every 12 months for coverage group E01. For E02, E03, and E 04, CARES automatically sends a redetermination package before the end of the certification period to the child's authorized representative before approving MA eligibility for another 12-month certification period.

- **II.** Procedures for MA case managers to initiate an Unscheduled Redetermination When a Child is Discharged from Out-of-Home Placement.
 - A. Medical Assistance eligibility may not be terminated based on a child's discharge from

OHP. The child's OHP MA eligibility must continue until it has been determined that no other MA or MCHP eligibility exists. The MA CM at the LDSS must initiate an unscheduled redetermination. To facilitate this process and the child's transition from OHP to the community or a LTC facility, at most 90 days of extended MA eligibility will be granted after the child leaves the OHP, allowing time for completion of an unscheduled redetermination. The following applies when the MA CM is notified by the service worker that the child has been discharged from OHP to the community or a LTC facility (e.g. residential treatment center, hospital, nursing care facility, ICF/MR):

- The MA CM must change the redetermination end date to allow the case go to into the CARES automatic redetermination cycle.
- O Since the child is still in an E-track coverage group as a household of one, CARES will send the DHR/FIA CARES 9709 application, rather than the CARES 9701 or MCHP application. CARES will send the redetermined package with the current worker of record as the contact person and with that MA CM's district office (DO) as the completion of the unscheduled redetermination.
- Income and resources will not be considered for the 90-day extension of MA eligibility but will be considered for the new period under consideration.
- B. The MA CM follows these procedures to initiate the unscheduled redetermination when a child is discharged from out-of-home placement:
 - 1. Leave the child as the head of household (HOH). Do not change information on the "DEM1" screen at this time, such as for living arrangements. Make no changes to the "UINC" screen for income or resources, except to delete the child's OHP income following the correct CARES processing steps or to make the changes indicated in #4 below for SSI income. Income and resources will not be considered for the extended period of MA eligibility after the discharge, only for the period under consideration for the unscheduled redetermination.
 - 2. The "ADDR" Screen must be updated to reflect the discharge address indicated by the service worker as the child's new address. Delete any authorized representative information on the "AUTH REP" Screen for the OHP case.
 - 3. After waiting at least a day to confirm that the address change has been updated on MMIS, the MA CM should process a request through CARES for a duplicate card to be issued to the discharge address for the child, using the following CARES procedures:
 - From the CARES Main Menu, select option "L- Financial Mgmt Misc."
 - On "LMEN" selection option "S- MA Card Reissuance" and enter the Client ID.

- o On "MACR" (MA Card Reissuance) Screen, verify information and select "Y" in the "Reissue Another Card" field. Press Enter to commit the request.
- o CARES will return to "LMEN" with a message of "Insert Successful".
- o Update the case narrative to reflect the duplicate card request.
- 4. For E01: A redetermination cannot be initiated on an E01 assistance unit (AU). Therefore, the redetermination end date cannot be shortened/changed on the MAFI screen, and CARES will not send a redetermination packet. The following procedure should be used to redetermine eligibility when a child, who is certified as an E01, is discharged from OHP.
 - Check SDX/SVES for whether the child is currently receiving Supplemental Security Income (SSI).
 - o If the child is an SSI recipient, redetermine eligibility from E01 to S02 effective the 1st day of the next month, either through "Add A Program" or by "J" screening the child's old SSI S02 AU.
 - Review the ADDR screen to assure the correct mailing address.
 Update accordingly.
 - o Change the Living Arrangement code on the DEM1 screen to "AH".
 - o Delete all unearned income on the UINC screen.
 - Add the child's SSI income back on the UINC screen as "SI", and also enter any other verified countable income (e.g., child support, SSA, etc.) with the correct coding.
 - If necessary during processing, waive adverse action to assure that the begin date for S02 eligibility is effective the 1st date of the following month.
 - o In order to avoid dual participation, the MA CM must "507" the pending S02 AU while processing the application month.
 - o Finalize the S02 AU and review the eligibility begin date.
 - o Fully narrate.
 - If the child does not receive SSI, change the coverage group from E01 to E02 so that an unscheduled redetermination can be initiated. This can be performed through Option L on the AMEN Screen via "Add-a-Program" to the existing E01 AU or by "J" screening a previous E02 AU.
 - o On the KIND Screen, place a "y" in the selection field for MA.
 - Continue through "Add-A-Program". On the CIRC Screen under unearned type/amounts, enter "SF" as the valid value for FAC foster care income (OHP Income) and \$1 as the amount value. This will cause the proper coverage group to populate on the INCH Screen.
 - On the INCH Screen, place a "y" in the selection field for E02 Med Coverage Group. Enter the current date as the application date, when the coverage group is changed from E01 to E02.
 - o Proceed through "Add-A-Program" screens to completion.

- On the AMEN Screen, the E02 AU Number will now be populated.
 Change the Option to "O" for Interview and process the case.
- o Review the ADDR Screen to assure the correct mailing address.
- Remember to enter closure reason code "507" to the E01 AU on the affiliated STAT screen in order to avoid dual participation in the ongoing months.
- o Change the Living Arrangement Code on the DEM1 Screen to "FC".
- On the UINC Screen, delete the E01 income by placing a "y" in the delete field and pressing PF 24. From the SHEL Screen, press PF7, which will return you to the UINC Screen. On the UINC Screen, enter "SF" and \$1 for unearned foster care income. Delete the "FC" or other E01 income from the UINC Screen for the ongoing month.
- Continue through the "Interview" process. Upon processing eligibility, confirm and allow closure of the E01 coverage to avoid dual participation in the ongoing month. Waive any adverse action, and override any closure notification.
- o Back at the AMEN Screen, select "P" to Process Application Months.
- Remember to "507" the E02 coverage for the current application month only to avoid dual participation with the E01 coverage already being received.
- On the MAFI Screen for the ongoing month during finalization of the E02 AU, shorten the "Redet End Date" to 90 days from the "Redet Begin Date". Complete CARES processing.

For E02, E03, or E04: The following procedures should be used to redetermine MA eligibility when a child who is certified as an E02, E03, or E04 is discharged from OHP.

- Using option "R" from "AMEN", initiate and complete an unscheduled redetermination for the existing E02, E03 or E04 AU.
- On the "MAFI" screen, adjust the redetermination end date to 90 days from the first day of the month following the month in which the MA CM became aware of the discharge from OHP, to allow inclusion into the CARES automatic redetermination cycle. Since the child remains in the "E" track until the redetermination is completed, the CARES 9708 application will be sent, even if the child is discharged back home.
 - o If the discharge date is during the first nine months of the child's certification period, the redetermination end date must be adjusted to 90 days from the first day of the month following the month in which the MA CM became aware of the discharge from OHP.
 - o If the discharge takes place in the last three months of eligibility, the MA CM <u>must initiate</u> the redetermination in the month following the month in which he or she became aware of the discharge. Complete the redetermination and shorten the "REDET END DATE" to 90 days from the "REDET BEGIN DATE". Following this procedure will ensure that CARES begins a "new

- redetermination cycle" and in doing so, will generate a new redetermination packet to the discharge address.
- o If the assistance unit (AU) was closed on CARES during the previous month due to failure to complete the redetermination process, the MA CM should "J" Screen the closed AU number from the first day of the month in which eligibility ended. Complete the application process and, in finalization, shorten the "REDET END DATE" to 120 days from the "REDET BEGIN DATE" to allow inclusion into the automatic redetermination cycle.

For an E-track child returned to an active F-track household:

The MA CM for the household's F-track case should be contacted. If there is sufficient information for the MA CM to determine that the child qualifies as a member of the F-track AU, there is no need to initiate an unscheduled redetermination for the child. If eligible, the child's E-track AU is closed effective the end of the month that the MA CM became aware of the child's discharge from the State's custody to the F-track household. The child is added as a member of the F-track AU effective the first day of the following month, so the household may begin to receive any public assistance for the child as soon as possible.

- 5. If a transfer of the case is necessary due to the child's new address and living arrangements, electronically transfer the case through CARES and send a copy of the paper file to the appropriate DO and/or MA CM. Set an Alert to notify any new MA CM that the above action was completed, and forward the case for follow-up.
- 6. Be sure to narrate on CARES all case action in each E-track case.
- **III.** Procedures for MA CM to Redetermine MA/MCHP Eligibility for Children Discharged from OHP.
 - A. <u>If the redetermination application is returned</u> by the child's parent or representative, pend the new medical coverage group, applying all applicable rules for AU composition, HOH, etc. A face-to-face interview is not required.
 - In "Interview", the MA CM updates the ADDR Screen and the DEM1 Living Arrangement.
 - The MA CM determines whether the child is living at home. The MA technical and financial eligibility factors must be met for all household members for whom benefits are requested. Since CARES will send the CARES 9708 form, the application will not collect information about other household members.
 - 1. The MA CM will contact the child's parent/representative to clarify who in the household is applying for benefits and for what type(s) of benefits. The MA CM will inquire about the income and resources of any household members who are

- applying or who are considered as Non-Members (NM) of the AU.
- 2. If necessary, the MA CM mails the CARES 9701 application to the parent/representative, specifying and highlighting the sections to complete (including signatures) that are not included on the CARES 9708 (for children considered as a household of one in an OHP, a LTC facility, or a home and community-based services waiver).
- 3. For the application month of the household's new AU, the "FINL RESP" code for the child must be entered as "NM" to avoid dual participation and insure that eligibility is determined correctly for any other AU members.
- If the MA CM determines that the child is eligible for MCHP in the P-track and there is no associated case (e.g. Food Supplement Program), the MA CM will change the D.O., electronically transfer the active P-track case, and mail a copy of the paper records to the appropriate LHD.
- If the MA CM determines that the child is eligible in a MA community or LTC category, or if there is an associated case for an MCHP AU (e.g. Food Supplement Program), the AU remains active at the LDSS.
- If the child moves into a household currently receiving TCA or if the HOH applies and is found eligible for TCA benefits for the child and other household members, the child's MA coverage may need to be changed to the "F" track before the end of the 90-day extended certification period. Then, the family may receive TCA and perhaps also FS benefits for the child as soon as possible, and for any other newly enrolled household members.
- If the child is discharged from OHP to a LTC (including an RTC or transferred to another D.O. and/or MA CM for a MA LTC eligibility determination.
- If it is determined that MA eligibility no longer exists for the child, the parent/representative must receive timely and adequate written notification, and the opportunity to request a hearing. A foster care child who is in the E03 State-only category because the MA citizenship requirements are not met will not be MA or MCHP eligible when discharged from the State's custody.
- B. If the redetermination application is not received by the end of the extended certification period, even after reminder notices, CARES will close the child's AU due to failure to complete the redetermination. The procedures in section 12 for tardy redeterminations apply if the application for continued eligibility is returned within four months of the redetermination due date, or if a new application is filed within that time frame.
- **IV.** Procedures for the MA CM to Follow When a Child is Aging-Out of Benefits for Out-of-Home Placements.

COMAR 07.02.11 specifies age limitations for services under the Out-of-Home Placement Program of the Department of Human Resources. The same age limitations apply for MA eligibility for children in OHP. Regardless of the circumstances, no one aged 21 or older should remain in the E-track, due to MA eligibility age restrictions for the E-track.

The MA CM must consult with the service worker about the child's OHP eligibility and manually set a "745" Alert for 90 days prior to when the recipient will "age-out" of eligibility for OHP before the child turns age 21.

- On the ALWG screen (Create Worker-Generated Alert), enter all the necessary information to set a "745" alert.
- In the "Display Date" field, enter the date 90 days prior to the first day of the month in which the client turns 21 years old.
- In the "Due Date" field, enter the month, day, and year in which the child turns 21 years old.
- The MA certification period must be adjusted by the MA CM so an unscheduled redetermination is initiated by CARES.
- Follow the steps outlined in this section for all E-track redeterminations.

If the recipient will be at least 21 years old at the end of OHP eligibility, the recipient's MA eligibility must be redetermined for the appropriate adult category (e.g. blind or disabled adult, parent or caretaker relative of a minor child). CARES will generate an "age alert" one month before the child turns 21.

NOTE: ALL CASE ACTIVITIES MUST BE FULLY NARRATED IN CARES.

(e) Refugees (G-Track)

Aliens who are classified as refugees, asylees, or victims of severe trafficking may be covered for MA services in the G-Track for at most eight months after either their month of U.S entry as a refugee or their effective month of asylum or victim of severe trafficking status.

Who are Refugees, Asylees, or victims of severe trafficking?

Refugees are persons granted protective status while abroad. Typically, they have been forced to flee their homeland and are unable to return. Asylees are persons granted protective status after entering the United States as defined by the Immigration and Naturalization Service (INS). Victims of severe trafficking means sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

Protection is granted only to those who have a well founded fear of being persecuted on any of the following ways:

- Race
- Religion
- Nationality
- Social group
- Political opinion

Refugees, granted asylees, and severe forms of trafficking victims are provided services through the Refugee Resettlement Services Program. (Refugee Resettlement Service program is governed by COMAR 07.03.23)

Refugee Medical Assistance Eligibility Criteria

- The first eight months after arrival to the United States
- Meet financial eligibility

Application

A person seeking services as a primary resident in the state of Maryland receives services at following locations:

- The Baltimore Resettlement Center (BRC)
- Suburban Washington Resettlement Center (SWRC) provides a wide array of resettlement services.

(f) X02 Undocumented or Unqualified Immigrants- Emergency Medical Services

Federally matched MA coverage for emergency medical services is provided to undocumented or unqualified immigrants who are residents and financially eligible for MA services but do not meet the citizenship or alien eligibility requirements.

What are X02 Services for Undocumented or Unqualified Immigrants?

• Emergency medical services for illegal or ineligible aliens

The following are some of the conditions considered Emergency Medical Services (EMS)

- Labor and delivery
- Dialysis and related services for aliens with end stage Renal Disease
- Individual with the diagnosed of AIDS

X02 Eligibility Criteria

Undocumented aliens

- Ineligible aliens
- Eligibility is determined based on a professional review of medical records to evaluate if the services received was an emergency service
- Qualified aliens who do not meet the five year bar don't meet the standard requirements for FAC, PW/MCHP
- The ineligible or undocumented pregnant alien can now file an application with the LDSS and LHD prior to the birth of a child
- When a determination of eligibility is completed a manual letter will be sent to recipients informing them of their eligibility
- Medical emergency other than labor and delivery, the CM must submit a DES 401
 application (the summary with admission and discharge dates, Emergency Room (ER)
 admission and ER documentations showing the medical services that were rendered were
 an emergency nature)

Submit by mail:

Delmarva Foundation for Medical Care, Inc Attn MDMA Acute, 6940 Columbia Gateway Drive Suite 420 Columbia, MD 21046-2788

Or submit via fax with a cover page to 1-888-513-1995, cover page should include: Facility Name, Patient Name and Date of Birth, Admission/Discharge Dates, Undocumented Alien Review (or x02)

Questions or concerning, providers should call Delmarva's provider services number, which is 1-866-571-3629.

(g) Aged, Blind, or Disable (ABD) (S-Track) or (T-Track) - Children or Adults in Long Term Care

Medicaid coverage for the ABD provides coverage for people who are Disabled or Blind or 65 or older or fatally ill and meet income and asset requirements. The initial certification period is 12 months six-months if eligible for spend-down. (Certification Period of COMAR 10.09.24.11)

• ABD MN Non-Spend-down (S98)

Federally matched MA is provided to ABD whose income and resources (including those of their spouse living with them) are within the MA community MN income and resource standards.

• ABD Medically Needy Spend-down (S99)

ABD, whose resources are within the MA community MN resource standard but whose income exceeds the medically needy income standard, qualify for federally matched MA when they spend-down their excess income-i.e., when their incurred medical expenses equal the amount of income that exceeded the income standard. Individuals eligible under MA spend-down may not be enrolled in HealthChoice.

Aged

- A person who is 65 years of age or older
- Aged is reached the day of the anniversary of birth
- LDSS can accept the SSA determination of age for persons receiving SSB

Blind

A person shall meet the definition of Blindness, according to COMAR 10.09.02b which states a condition in which a person is certified by an ophthalmologist as having either central vision acuity 20/200 or less in the better eye with correcting glasses, or defect in which the peripheral filed has contracted to such an extent that the diameter of the field visual test subtends an angular distance of no greater than 20 degrees or Missing both eyes.

Disabled

- Disability determination must be made by the SSA or the State Review Team (SRT).
 SRT is a unit within the DHR. DHR/FIA responsible for making a disability determination
- To be determined disabled, a person must have a disability that is expected to last at least 12 months or may result in death
- The determination by SSA is binding on the State until it is changed by the SSA

ABD Eligibility Criteria

- Recipients of SSI from the SSA are automatically eligible for Medicaid.
- Individuals who lost SSI eligibility due to an annual cost of living increase in their Social Security income or a change in the federal disability definition are eligible for Medicaid.
- Individuals qualify as ABD MN, if they are ABD and their household income and assets do not exceed the Medicaid income and asset standards for the MN (e.g., \$350 per month in income and \$2,500 in assets for a household of one person). The allowed income and assets vary depending upon family size. (Coverage Groups 03 of COMAR 10.09.24.03)
- Individuals qualify through ABD spend-down, if they are ABD persons whose household
 assets meet the medically needy standards but whose household income exceeds the
 Medicaid income limit for the MN. The individual becomes Medicaid-eligible once
 incurred medical expenses total or exceed that excess amount. (COMAR 10.09.24.03)

• Recipients of Public Assistance to Adults (PAA) are automatically eligible for Medicaid. PAA is a state funded program through the DHR, which supports ABD adults living in assisted living facilities, Project HOME adult foster care, or residential rehabilitation

County	Address	Telephone/Fax Number

facilities of DHMH.

Application

- Meet the definition of ABD (COMAR 10.09.02b)
- Meet financial eligibility

Attachment A Local Department of Social Services

Baltimore City DSS	Talmadge Branch Building (Walk In)	443-423-6300
Baltimore City B33	1910 N. Broadway Baltimore MD 21213	443-423-6501 Fax
	PO Box 17466 (Mail Only) Baltimore MD 21203-7466	
Allegany County DSS	1 Frederick Street Cumberland, MD 21502	301-784-7000 301-784-7222 FAX
Anne Arundel County DSS	80 West St 2nd Floor Deck Annapolis, MD 21401	410-269-4500 410-974-8566 FAX Glen Burnie: 410-421-8550
Baltimore County DSS	6401 York Road Towson, MD 21212	410-853-3000 410-853-3955 FAX Catonsville: 410-853-3450 Dundalk: 410-853-3400 Essex: 410-853-3800 Reisterstown: 410-853-3010
Calvert County DSS	200 Duke Street Prince Frederick, MD 20678-0100	443-550-6900 410-286-7429 FAX
Caroline County DSS	300 Market Street Denton, MD 21629	410-819-4500 410-819-4501 FAX
Carroll County DSS	10 Distillery Drive Westminster, MD 21157	410-386-3300 410-386-3429 FAX
Cecil County DSS	Elton District Court/ Multi-Service Building 170 E. Main Street Elkton, MD 21921	410-996-0100 410-996-0464 FAX Calls from Rising Sun: 410-658-2145
Charles County DSS	200 Kent Avenue LaPlata, MD 20646	301-392-6400 301-870-3958 FAX
Dorchester County DSS	P.O. Box 217 (Mail Only) 627 Race Street (Walk In) Cambridge, MD 21613	410-901-4100 410-901-1047 FAX
Frederick County DSS	Frederick, MD 21705 100 E. All Saints Street (Walk In) Frederick, MD 21701	301-600-4555 301-600-4550 FAX
Garrett County DSS	12578 Garrett Highway Oakland, MD 21550-0556	301-533-3000 301-334-5449 FAX
Harford County DSS	2 South Bond St Bel Air, MD 21014	410-836-4700 410-836-4945 FAX 410-879-4500
Howard County DSS	7121 Columbia Gateway Dr. Columbia MD, 21046	410-872-8700 410-872-4231
Kent County DSS	350 High Street P.O. Box 670 Chestertown, MD 21620	410-810-7600 410-778-1497 FAX

Montgomery County DHHS	1301 Piccard Drive, 2nd Floor Rockville, Md. 20850	240-777-4600 240-777-4100 FAX Germantown: 240-777-3420 240-777-3477 FAX Silver Spring: 240-777-3100 240-777-3070 FAX
Prince George's County DSS	425 Brightseat Road Landover, MD 20785	301-909-6000 301-909-6067 FAX Hyattsville: 301-209-5000 301-209-5276 FAX South County: 301-316-7700 301-316-7701 FAX
Queen Anne's County DSS	125 Comet Drive Centreville, MD 21617	410-758-8000 410-758-8110 FAX
St Mary's County DSS	Joseph D. Carter Building 23110 Leonard Hall Drive P.O. Box 509 (Mail Only) Leonardtown, MD 20650	240-895-7000 240-895-7099 FAX
Somerset County DSS	P.O. Box 369 (Mail Only) 30397 Mt. Vernon Road Princess Anne, MD 21853	410-677-4200 410-677-4300 FAX
Talbot County DSS	301 Bay Street P.O. Box 1479 (Mail Only) Easton, MD 21601	410-770-4848 410-820-7117 FAX
Washington County DSS	122 N. Potomac Street P.O. Box 1419 (Mail Only) Hagerstown, MD 21740	240-420-2100 240-420-2299 FAX
Wicomico County DSS	201 Baptist Street, Suite 27 Salisbury, MD 21801	410-713-3900 410-713-3910 FAX
Worcester County DSS	299 Commerce Street P.O. Box 39 (Mail Only) Snow Hill, MD 21863	410-677-6800 410-677-6810 FAX

Attachment B- Local Health Department

County/Program	Address	Telephone/Fax Number
Allegany Maryland Children's Health Program	12501 Willowbrook Rd. P.O. Box 1745 S.E. Cumberland, MD 21502	(301) 759-5076 (301) 777-2097 FAX
Anne Arundel County Department of Health Maryland Children's Health Program	1 Harry S. Truman Pkwy. Suite 200 Annapolis, MD 21401	(410) 222-4792 (410) 222-4391 FAX
Baltimore County Baltimore County Health Department MCHP Program	8501 LaSalle Rd. Suite 103 Towson, MD 21286	(410) 887-2957 (410) 887-8095 FAX
Baltimore City Baltimore Health Care Access MCHP	One Calvert Plaza 201 E. Baltimore Street 9th Floor Baltimore, Md. 21202	(410) 649-0512 (410) 649-0533 FAX
Calvert Maryland Children's Health Program	P.O. Box 980 Prince Frederick, MD 20678	(410) 535-5400 (301) 855-1353 (410) 535-1955 FAX
Caroline Caroline County Health Department	P.O. Box 10 (Mail Only) 403 S. 7th Street Denton, MD 21629	(410) 479-8004 (410) 479-0244 FAX
Carroll County Health Department	290 S. Center Street P.O. Box 845 Westminster, MD 21158	(410) 876-4916 (410) 876-4905 FAX
Cecil Maryland Children's Health Program	401 Bow Street Elkton, MD 21921-5511	(410) 996-5126 (410) 996-5124 FAX
Charles Co. Nursing & Community Health Services	P.O. Box 1050 White Plains, MD 20695-1050	(301) 609-6869/6868/6883 (301) 609-6837 (301) 609-6899 FAX
Dorchester Dorchester County Health Department	503-B Muir Street Cambridge, MD 21613	(410) 228-3294 (410) 228-8976 FAX
Frederick Frederick County Health Department	350 Montevue Lane Frederick, MD 21702	(301) 600-3124 TEL (301) 600-3111 FAX
Garrett County Health	1025 Memorial Drive Oakland, MD 21550	(301) 334-7700 (301) 334-7701 FAX
Harford Maryland Children's Health Program	120 S. Hays St. P.O. Box 797 Bel Air, MD 21014	(443) 643-0343 (443) 643-0344 FAX
Howard County Health Department	7180 Columbia Gateway Drive Columbia, MD 21046	(410) 313-7500 (410) 313-5838 FAX

Kent County Health Department Maryland Children's Health Program	125 S. Lynchburg Street Chestertown, MD 21620	(410) 778-7023 (410) 778-7019 FAX
Montgomery Service Eligibility Unit	1335 Piccard Drive, Upper Level Rockville, MD 20850	(240) 777-3120 (240) 777-1013 FAX
	8630 Fenton Street, 10th floor Silver Spring, MD 20910	(240) 777-3066 (240) 777-1307 FAX
	12900 Middlebrook Road Germantown, MD 20874	(240) 777-3591 (240) 777-3563 FAX
Prince George's Maryland Children's Health Program	425 Brightseat Road, Suite 101 Landover, MD 20785	(888) 561-4049 (301) 324-2809 FAX
Queen Anne's	206 N. Commerce Street Centreville, MD 21617	(410) 758-0720 (443) 262-9357 FAX
St. Mary's MCHP Eligibility & Outreach	P.O. Box 316 21580 Peabody Street Leonardtown, MD 20650-0316	P.O. Box 316 21580 Peabody Street Leonardtown, MD 20650-0316
Somerset Somerset County Health Department	7920 Crisfield Highway Westover, MD 21871	(443) 523-1700 (410) 651-2572 FAX
Talbot County Health Department	100 S. Hanson St. Easton, MD 21601	(410) 819-5670 (410) 819-5691 FAX
Washington Maryland Children's Health Program	1302 Pennsylvania Avenue Hagerstown, MD 21742	(240) 313-3330 (240) 313-3334 FAX
Wicomico Maryland Children's Health Program	(Mail Only) 108 E. Main Street (In Person) 300 West Carroll St. Salisbury, MD 21801	(410) 543-6944 (410) 543-6568 FAX
Worcester Berlin Health Center	9730 Healthway Drive Berlin, MD 21811	(410) 629-0164 (410) 957-2005 (410) 629-0185 FAX

(h) Women's Breast and Cervical Cancer Health Program (WBCCHP)

I. Introduction

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (the Act) (Public Law 106-354) amends Title XIX of the Social Security Act to give states the option to cover a Medical Assistance (Medicaid) categorically needy coverage group for uninsured women between 40 and 64 years old, who are screened through the Centers for Disease Control (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and are diagnosed as in need of treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer. Coverage under this program is subject to the availability of State and federal funds. This Medicaid coverage group is named the Women's Breast and Cervical Cancer Health Program (WBCCHP), effective April 1, 2002.

Services provided for Women with Breast or Cervical Cancer

This program covers women for MA services who have been screened by the Breast and Cervical Cancer Program (BCCP) through the LHD (which has certain income limitations) and diagnosed with breast or cervical cancer. The following requirements must be met:

- Be a woman between the age of 40 and 64 years old, who is a Maryland resident;
- Be uninsured, or have insurance that does not cover cancer treatment;
- Be in need of treatment; and
- Not be eligible for Medicaid or Medicare.

There are no additional income and assets limitations, as long as the woman is screened through the BCCP program under the DHMH Public Health Services program and meets other eligibility criteria (i.e. residency, citizenship, social security number).

(Section 300.1(h) Attachment A, WBCCHP Local Program Coordinators)

Application

- Women can obtain applications to enroll in the program from the Breast and Cervical Cancer Program coordinator at their LHD,
- The DHMH, Center for Cancer Surveillance and Control,
- Applications can also be completed at the offices of participating providers
- LDHs will forward complete applications to the DHMH case reviewer for eligibility requirements. Eligibility determinations will be the responsibility of the DHMH
- Women applying for the program must submit confirmation that breast or cancer screening services were received through the BBCCP a physician, certification of biopsy, diagnosis and the need for treatment

Certifications and Redeterminations:

- The initial certification period for the WBCCP is 12 months
- Eligibility will be redetermined by the DHMH reviewer prior to the end of 12 months
- The redetermination period of eligibility will be the lesser of 12 months or the estimated length of treatment as indicated on the certification of diagnosis form completed by the woman's physician or certified registered nurse practitioner.

Attachment A- Women's Breast and Cervical Cancer Health Program (WBCCHP)

Program	Coordinator(s)	Email Address	Telephone Number	Fax Number
Allegany	Joanna Schroyer	jschroyer@dhmh.state.md.us	(301) 759-5083	(301) 777-2053
Anne Arundel	Amy Kane	hdkane00@aacounty.org	(410) 222-4792	(410) 222-4391

Baltimore County	Constance	cnotaro@baltimorecountymd.gov	(410) 853-3311	(410) 853-3211
	Notaro Debbie Wilson	dawilson@baltimorecountymd.gov	(410) 887-3432	(410) 887-3421
Calvert	Sharon Owens	sowens@cmhlink.org	(410) 286-7992	(410) 286-7990
Caroline	Leigh Marquess	leigh@dhmh.state.md.us	(410) 479-8080	(410) 479-2014
	Laura Patrick	laurap@dhmh.state.md.us		
Carroll	Judy Trickett	jtrickett@dhmh.state.md.us	(410) 876-4916	(410) 876-4905
Cecil	Brenda Sochurek	bsochurek@dhmh.state.md.us	(410) 996-5168	(410) 996-5169
Charles	Dawn Cox	dawnc@dhmh.state.md.us	(301) 609-6861 /6883,6952, 6837,6861	(301) 609-6899
Dorchester	Gale Jackson	gjackson@dhmh.state.md.us	(410) 228-3223	(410) 228-8976
Frederick	Lori Stockman	lstockman@frederickcountymd.gov	(301) 600-3124	(301) 600-3372
	Roseann Russo	rrusso@frederickcountymd.gov		
Garrett	Caroline Evans	cevans@dhmh.state.md.us	(301) 334-7720	(301) 334-7771
Harford	Wendy Richard	wrichard@dhmh.state.md.us	(410) 612-1780	(410) 612-9184
Howard	Sarah Muse	smuse@howardcountymd.gov	(410) 313-5845	(410) 313-5838
Kent	Andrea Edwards	aedwards@dhmh.state.md.us	(410) 778-7035	(410) 778-7019
Montgomery	Donna Carter	Donna.Carter@montgomerycountymd.gov	(240) 777-3120	(240) 777-1013
Prince George's	Myra Ball	mball@co.pg.md.us	(301) 883-3525	(301) 883-3561
	Elaine Stillwell	ejstillwell@co.pg.md.us		
Queen Anne's	Cheryl Salaski	csalaski@dhmh.state.md.us	(443) 262-4509	(443) 262-9351
St. Mary's	Lori Norton	nortonl@smhd.com	(301) 475-4275	(301) 475-4350
Somerset	Cynthia Abbott	CINDY.Admin.Somerset@dhmh.state	(443) 523-1752	(410) 651-3425
	Kristin Bradshaw-Dicintio	KRISTINBR.Admin.Somerset@dhmh	(443) 523-1754	
Talbot	Caron West	caron@dhmh.state.md.us	(410) 819-5600	(410) 819-5683
		hald@dhht-td	(240) 313-3235	(240) 313-3422
Washington	Wendi Beckley	wbeckley@dhmh.state.md.us	(240) 313 3233	(210)3133122
Washington Wicomico	Wendi Beckley Sylvia Kumer	sward@dhmh.state.md.us	(410) 543-6944	(410) 543-6568

COMAR 10.09.24.03

ſ	Baltimore City	Linda Wieczynski	Linda.Wieczynski@medstar.net	(410) 649-0512	(410) 649-0533
	University Care	Rhonda Silva	rsilva@umm.edu	(410) 328-4673	(410) 362-5347

Background

Federal legislation requires a state's Medicaid Program to pay the Medicare B premiums, coinsurances and deductibles for Medicare beneficiaries whose countable income and/or resources are above the applicable amount in a state's medically needy income and resources standards but are at or below the applicable amounts in the QMB income and resource standards, provided the applicant meets all other regular Medical Assistance (MA) eligibility requirements.

A Qualified Medicare beneficiary (QMB) is:

- A person entitled to Medicare hospital benefits under Part A. (This includes a person entitled to hospital insurance benefits by reason of enrollment in the premium paying Part A program);
- A person who is not otherwise eligible for MA due to excess or resources;
- Countable income does not exceed 100 percent of the poverty income guidelines. The
 poverty income guidelines are issued annually by the U.S. Department of Health and
 Human Services
- Countable resources do not exceed twice the applicable SSI resource limit;
- A blind or disabled Medicare beneficiary who is a parent may request to be included in an FAC unit with their child/children; if they decide to do so, they can still receive QMB benefits

A QMB must also meet the general non-financial requirements or conditions of eligibility for MA of COMAR 10.09.24 such as filing an application, enumeration, citizenship, identity, residency and assignment of rights.

General Explanation

The QMB Buy-in provision is an extension of the current MA Program which provides for State payment of the Medicare Part B premium, co-insurances and deductibles. Buy-in coverage for a person who is determined to be a QMB, as defined in Section B of this part, is for a person who is otherwise ineligible for MA. (NOTE: Medicare Beneficiaries who are eligible for MA are also eligible for the buy-in coverage concurrent with their MA eligibility. The procedures relating to this group of dually eligible persons are included in Part II.)

The general MA policies and procedures apply to the eligibility determination. There are, however some differences that are addressed in this section. The differences are:

- Only the Medicare beneficiary is included in the assistance unit;
- The income and resource deeming methodology from an ineligible spouse (parent);

- Retroactive coverage does not apply;
- Spend-down does not apply; and
- A higher income and resource standard.

The effective date of the Buy-in coverage is January 1, 1989. Scheduled redeterminations are required at 12-month intervals. Eligible persons will be issued a gray and white QMB identification card. A QMB eligible person or couple whose resources are within Schedule MA-2, but whose income exceeds Schedule MA-1 may also qualify for regular MA under spend-down. Refer to section K and L of this part for complete procedures. If a Buy-in recipient meets MA spend-down eligibility, the case status changes from QMB Buy-in only to MA and Buy-in coverage (dual eligibility).

Nothing in this section changes the eligibility determination methodology of a Medicare Beneficiary who is ineligible for the Buy-in.

Applicable Regulations

Since the majority of Medicare beneficiaries are aged (65 years old or older), the ABD rules will generally apply to the eligibility determination. A smaller number of beneficiaries are disabled, some of whom are the parents of minor children who live in the home.

Application

- A completed DHR/FIA 9705 application form by mail
- QMB applications can be used when applying for QMB/SLB (Specified Low income Medicare Beneficiaries)

The procedures in COMAR 10.09.24.04 are applicable. The application form DHR/FIA 9705 is the instrument by which eligibility information is collected. Unless specifically stated otherwise, the filing of an application form represents an application for both MA and the QMB Buy-in only coverage. In the case of a Medicare beneficiary request to apply for the Buy-in only coverage, that request may be honored and the local department is not required to determine MA eligibility for other family members.

Consistent with COMAR 10.09.24.04, which allows an applicant to decide the category in which he/she wants eligibility established, a blind or disabled Medicare beneficiary who is a parent may be included in an FAC unit with his/her children and spouse if he/she is to do so.

QMB Eligibility Criteria

NOTE: For the purpose of this release, the terms "ineligible spouse" and "ineligible child" apply to one who is not receiving or entitled Medicare.

Assistance Unit Requirements

An AU unit may include only a person who is a Medicare beneficiary. In the case of a married couple both of whom are Medicare beneficiaries; both spouses are included in the same unit and their eligibility is tested together as a couple. Otherwise, the unit will include only one person. If only one of the married couple is a Medicare beneficiary, only the Medicare beneficiary is included in the unit. However, the income and resources of the ineligible spouse are considered. (Total countable resources of a couple are combined and measured against the QMB resource standard for two persons). Children are not counted in the resource measurement. Refer to Attachment A, 2012 Dual Eligible Standards. Refer to Section G for income deeming requirements.

Note: Ineligible Spouse applies to one who is not receiving or entitled to Medicare.

Determination of Countable Income

Countable income is evaluated in accordance with COMAR 10.09.24.07. The countable income to be considered is that of the assistance unit member(s) (Medicare beneficiary/ beneficiaries) or, in the case of an ineligible spouse, that of the ineligible spouse as well. The exclusions and disregards apply to the income that is considered available to the Medicare beneficiary, including that of the ineligible spouse. The Social Security cost-of-living adjustments (COLAS), effective January, are to be disregarded in determining income eligibility through April. The first month in which the COLAS are to be applied is May. Countable income, after disregards, is measured against the QMB income standard. If a Medicare beneficiary has an ineligible spouse and ineligible children, the income of the ineligible spouse must be considered in determining the Medicare beneficiary's eligibility. The procedures for determining the amount of the ineligible spouse's income to be deemed to the Medicare beneficiary spouse are in Section G of this part.

Resource Consideration

The countable resources to be considered are those of the applicant and the spouse of the applicant whether or not the spouse is also eligible. Countable resources are measured against the QMB resource standard for one person if the Medicare beneficiary has no spouse, or against the QMB resource standard for two persons if there is a spouse.

No other family members are included in the measurement. If there are excess resources, the individual or couple is determined ineligible.

Deem Income from an Ineligible Spouse to a Medicare Beneficiary

If an ineligible spouse lives in the same household and is the parent of a dependent ineligible child or children living in the home, in order to determine the amount of the ineligible countable income in the following order:

- First (using the ABD exclusions and disregards in COMAR 10.09.24.07), determine how
 much unearned and earned income the ineligible spouse has. The ABD disregards are
 applied in the following order:
 - Apply the \$20.00 disregards ABD general disregard to any unearned income;
 if none, apply it to the earned income.
 - Next, apply the earned income disregard (\$65+.5 or remainder) to the remaining earned income.
- Then deduct an allocation for each of the ineligible children living in the household. Exceptions: Do not allocate for ineligible children who are receiving income maintenance payments. These payments are made under:
 - The Family Investment Program (TCA);
 - o Title XVI of the Social Security Act (SSI, including State Supplement);
 - o The Refugee Act of 1980 (those payments based on need);
 - o The Disaster Relief Act of 1974:
 - o State or local government assistance programs based on need; and
 - o U.S. Veteran Administration Programs (those payments based on the need).
- The allocation for each child is the difference between the applicable SSI payment rate for a couple and that for an individual minus the amount of his/her income. These allocations are first deducted from the ineligible spouse's unearned income. If the ineligible spouse does not have enough unearned income to cover the allocations, the balance is deducted from the ineligible spouse's earned income. The amount of the allocation automatically increases whenever the SSI payment standard increases. The amount of the allocation to be used to determine the amount of the benefit for a current month is based on the payment rate that applied in the second prior month.

NOTE: The allocation of income applies only to the ineligible children and income of the ineligible spouse. Do not allocate to children the income of the Medicare beneficiary.

Determining the Medicare Beneficiary's Eligibility for the Buy-in Coverage.

Compare the amount of the ineligible spouse's income which remains after the appropriate allocations, to the difference between the applicable SSI payment rate for a couple and that for an individual. If the amount is not more than the difference between the applicable SSI payments rate for a couple and that for an individual, there is no income to deem from the ineligible spouse to the Medicare beneficiary. In this case, compare only the Medicare beneficiary's own countable income to the QMB income standard for one person to determine if the Medicare beneficiary is eligible for the buy-in coverage.

- If the amount of the ineligible spouse's income that remains after appropriate allocations is more than the difference between the applicable SSI payment standard for a couple and that for an individual, take the following steps:
 - o Combine the remainder of the ineligible spouse's unearned income with the Medicare beneficiary's own unearned income and the remainder of the ineligible spouse's earned income with the Medicare beneficiary's own earned income.
 - o Apply all appropriate income exclusions and disregards of COMAR 10.09.24.07.
 - o Compare the remainder to the QMB income standard for 2 persons. If the remainder is equal to or less then the QMB income standard for 2 persons, the Medicare beneficiary is eligible for the Buy-in coverage.
 - o If the net countable income exceeds the applicable QMB standard, and the resources are within Schedule MA-2; the Medicare Beneficiary is ineligible for the Buy-in. Recalculate the income for regular MA based on Schedule MA-1 and take appropriate action based on the spend-down provisions. Refer to sections K and L. If, under this same circumstance, the resource exceeds Schedule MA-2, the person is totally ineligible for MA.

Income Deeming Examples

Following are examples of how to deem income from an ineligible spouse to an eligible spouse.

Example 1:

Mr. P, a disabled Medicare beneficiary, applies for the Medicare Buy-in coverage. He lives with his wife and 14-year old son, neither of whom is a Medicare beneficiary. Since Mr. P has requested Buy-in-coverage only, his is a one-person ABD assistance unit. Mr. P. and his son receives OASDI (\$350 and \$100 monthly, respectively) and Mrs. P is employed and earns \$550.00 monthly. The family has countable resources of \$3,000, therefore, Mr. P is resource eligible. To determine his income eligibility, the income of his wife is taken into account. Take the following steps to determine if any of the wife's income is deemed to be available to Mr. P:

• Step 1-Determination of Mrs. P's Countable Income Apply the \$250.00 ABD general and earned income (EI) (\$65.00 + ½ of remainder) disregards. Note: the \$20.00 general disregard is first applied to unearned income. If there's no unearned income, then apply to the E.I.

Mrs. P's unearned income	\$ 0.00	\$550.00
Mrs. P's earned income	\$550.00	- <u>20.00</u>
		530.00
		<u>-65.00</u>
		\$465.00÷2=\$232.50

• Step 2- Determination of Income to be deemed from Ineligible Spouse (Mrs. P)

Income allocation for ineligible child (difference between SSI payment rate for a couple and an individual):

a.\$553.00-\$368.00=\$185.00

Reduce child's allocation amount of his/her own income.

Allocation for child	\$185.00
Child's income	- <u>100.00</u>
(Difference between child's allocation and	\$85
Child's income)	

b. Calculate Mrs. P's remaining income after allocation.

Mrs. P's income	\$232.00
Child's allocation	<u>-85.00</u>
Mrs. P's remaining income	\$147.50

Since Mrs. P's remaining income (\$147.50) is not more than the difference between the applicable SSI payment standard for a couple and that for an individual (\$185.00), there is no income to deem from Mrs. P to Mr. P.

Step 3-Calculation of Mr. P's Income for Buy-in Eligibility Decision

a.	OASDI-Mr. P's unearned income	\$415.00
	Apply the \$20 ABD general disregard	<u>-20.00</u>
	Net countable income	\$395.00

b. Compare Mr. P's net countable income to the QMB income standard for 1 person (425.). \$395.00

-<u>425.00</u> \$ -0-

- c. Mr. P's net income of \$395 is within the QMB income standard of \$425.0. His resource is within the QMB resource standard of \$4000.00.
- d. Decision: Mr. P is eligible for the Buy-In coverage.

Example II:

Mrs. K a disabled Medicare Beneficiary, applies for the Medicare buy-in coverage. She lives with her husband and two children, ages 8 and 10 years old. Since Mrs. K has requested Buy-In coverage only, hers is a one-person, ABD AU.

Mrs. K and her two children receive OASDI (\$325 and \$135 monthly, per child, respectively). Mr. K is employed and receives \$525 weekly.

The family has countable resources of \$3800; therefore, Mrs. K is resource eligible. To determine Mrs. K's income eligibility, the income of Mr, K must be taken into account.

Take the following steps to determine if any of Mr. K's income is deemed to be available to Mrs. K.

Step 1-Determination of Mr. K's Countable Income

Multiply Mr. K's weekly E. by 4.3 to arrive at monthly income, and apply the \$20.00 ABD general and E.I (\$65.00-½ of remainder) disregards. (If paid bi-weekly multiply income by 2.15 to arrive at monthly income.)

Mr. K's U.I.	\$0.00	\$525.00
Mr. K's E.I.		×4.3
		2257.50
		-20.00
		2237.50
		<u>-65.00</u>
		\$2172.50÷2=\$1086.25

Step 2-Determination of Income to be deemed from Ineligible Spouse (Mr. K) (Income allocation for ineligible child-differences between SSI payment rate for couple and an individual):

a. \$553-\$368=\$185.00

b. Reduce child's allocation by the amount of his/her income:

\$185.00×2	\$370.00
\$100.00	- <u>270.00</u>
\$135.00×2	\$100.00

(Difference between children's allocation and income)

c. Calculate Mr. K's remaining income after allocation.

Mr. K's income	\$1086.25
Children's allocation	- <u>100.00</u>
Mr. K's remaining income	\$986.25

Since Mr. K's remaining income (\$986.25) is more that the difference between the applicable SSI payment standard for a couple and that for an individual (\$185.00), the remainder of income must be added to Mrs. K's income to determine her eligibility for Buy-In coverage.

Step 3-Calculation of Mrs. K's Income for Buy-In Eligibility Decision

a. Combine Mr. & Mrs. K's unearned income and apply the \$20.00 ABD general disregard.

Mr. K's unearned income	\$ 0.00	\$325.00
Mrs. K (OASDI)	<u>+325.00</u>	<u>-20.00</u>
	\$325.00	\$305.00

b. Combine the remainder of Mr. and Mrs. K's E.I. and apply the ABD E.I. (\$65.00+1/2 of remainder) disregard.

Mr. K's E.I	\$986.25
Mrs.K's E.I	<u>+ 0.00</u>
	\$986.25
	<u>-65.00</u>
	\$921.25 ÷2=\$460.63

c. Combine and compare Mr. and Mrs. K's U.I and E. I to the QMB income standard for 2 people (\$575.00).

U.I	\$305.00	\$765.63
E.I	+ <u>460.63</u>	- <u>575.00</u>
	\$765.63	\$190.63

- d. Mrs. K's total income is \$190.63 over the QMB income standard for 2 people.
- e. Decision: Mrs. K is not eligible for Buy-In coverage, due to excess income.

Note: Because resources also exceed applicable amount in Schedule MA-2the case is not preserved for MA spend-down eligibility.

Example III:

Mr. C, a disabled Medicare beneficiary, applies for the Medicare Buy-in coverage. He lives with his wife and their two children, who are not Medicare beneficiaries. Since Mr. C has requested Buy-in coverage only, his is a one-person assistance unit. Mr. C and his two children receive OASDI (\$405, and \$100 monthly, per child, respectively). Mrs. C earns \$430.00 monthly and receives \$100.00 monthly unearned income. The family has countable resources of \$2,900; therefore, Mr. C is resource eligible. To determine his income eligibility, the income of his wife is taken into account. Take the following steps to determine if any of Mrs. C's income is deemed to be available to Mr. C.

Step 1-Determination of Mrs. C's Countable Income

Apply the \$20.00 ABD general and E.I. (\$65 -1/2 of remainder) disregards

\$100.00	\$430.00
-20.00	<u>-65.00</u>
\$ 80.00	\$365.00 ÷2=\$182.50

Step 2-Determination of Income to be deemed from Ineligible Spouse (Mrs. C) Income allocation for each ineligible child-difference between SSI payment rate for a couple and an individual):

- a. \$553-\$368=\$185.00
- b. Reduce each child's allocation by the amount of his/her own income:
- c. Calculate Mrs. C's remaining income after allocation. Note: Child allocation is first deducted from unearned income. If there's not enough unearned, the remainder is deducted from E.I.

+---

Mrs. C's unearned income:	\$80.00
Children's allocation	- <u>170.00</u>
Mrs. C's remaining income	\$90.00
Mrs. C's earned income	\$182.50
Allocation carryover	<u>-90.00</u>
Mrs. C's remaining income	\$92.50

Since Mrs. C's remaining income (\$92.50) is not more than the differences between the applicable SSI payment standard for a couple and that for an individual (\$185.00), there is no income to deem from Mrs. C to Mr. C.

Step 3-Calculation of Mr. C's Income for Buy-In Eligibility Decision

a.	OASDI- Mr. C's unearned income	\$405.00
	Apply the \$20 ABD general disregard	<u>-20.00</u>
	Net countable income	\$385.00

b. Compare Mr. C's net countable income to the QMB income standard for 1 person (\$425).

\$385.00 -425.00 \$ -0-

- c. Mr. C's net income of \$385.00 is within the QMB income standard of \$425.00. His resources are within the QMB resource standard of \$4,000.
- d. Decision: Mr. C is eligible for the Buy-in coverage.

Overall Decision:

- a. Eligible-Notice Requirement: Use DES 202.
- b. Ineligible solely due to excess income-Notice Requirements Use DHMH 4213B and DHMH 4200A
- c. MA ineligible due to excess resources or non-financial factors-Notice Requirement: Use DES 300.

Income Calculation for Spouses When Both Are Medicare Beneficiaries with No Children

When both spouses are Medicare beneficiaries and they are not the parents of any dependent children living with them, their eligibility for the Buy-in is determined together as a single unit. Follow the standard MA ABD income calculation using the regular MA disregards of COMAR 10.09.24.07L.

If the net countable income and countable resources are equal to or less than QMB income and resource standards for 2 persons, each spouse is eligible for the Buy-in.

The same procedure applies when one of the spouses is not a Medicare beneficiary. The single difference is that the ineligible spouse is not certified for Buy-in. if the ineligible spouse requests assistance; his/her MA eligibility must be tested separately under the existing MA or MASO rules as appropriate. Under this circumstance, the income and resources of the QMB are considered in determining the non-QMB eligible spouse's MA eligibility and measured against the MA-I and MA-2 standards for 2 persons.

Certification (Buy-in Only)

Certification for the Buy-on coverage is for a 12-month period and begins the month following the month the person is determined eligible. Certification continues until the person is determined ineligible.

(Retroactive coverage does not apply to a person who is eligible only for the Buy-on.) Do not confuse the month a person becomes eligible with the month the CM.

Completion of the DHMH 2583 (Insurance Reporting Form) is required for eligible Buy-In case. There is a notice requirement for CM to send appropriate notice to client.

Scheduled Redeterminations

Scheduled redeterminations for persons certified for the Buy-in only are conducted once every 12 months. If a recipient is determined ineligible, the local department must take the necessary action to cancel the case in accordance with timely and adequate notice requirements. The cancellation is effective no earlier than the month ineligibility is determined. Notice Requirements: A person may file a new application at any time. The application process explained in this part applies to reapplication.

Unscheduled Redeterminations

Even though QMB cases are certified for 12-month periods and scheduled redeterminations are due once every 12 months, in the event of an unscheduled redetermination, for calculation purposes, it is necessary to split the 12 months into two six-month periods.

Upon notice of a change in circumstances, it is necessary to determine if the recipient continues to be eligible for the remainder of the current certification period. In the case of an increase in income, in order to determine continued eligibility, it is necessary to add the new income to be received and compare the total to be received compare the total to the applicable amount in the QMB income standard. If the total amount, after application of the disregards, is equal to or less than the allowable QMB standard, the recipient remains eligible for the balance of the current period. No notice requirements. No further action needed. 268-8229

If the income exceeds the allowable amount, the recipient is ineligible. The local department must take action to cancel the case in accordance with timely and adequate notice requirements.

COMAR 10.09.24.03

Notice Requirement: Use DES 303. The person may file a new application at any time. The

application process explained in this release also applies to reapplications.

If the unscheduled redetermination results in ineligibility for any other reason, the local department must take action to cancel the case in accordance with timely with adequate notice

requirements. No further action is required. The person may file a new application at any time.

NOTE: A case may be closed no earlier than the month ineligibility was determined.

• Improper Program Payment

Follow existing Manual procedures if erroneous payments result from the actions, inactions

or delayed actions on the part of either the recipient or the local department.

A QMB Recipient Right to Apply for MA Spend-down

 A QMB eligible person or couple whose resources are within the MA requirement, but whose income exceeds schedule MA-1 (income standards) may also qualify for regular

MA under spend-down.

• A recipient in QMB Buy-in only that meets spend-down is considered dual eligible.

• Excess income for spend-down purposes is based on the amount in excess of the

applicable amount in Schedule MA-1.

If applicable QMB eligible person is ineligible for MA solely because of excess income, the eligible person may apply for a status change from QMB to MA spend-down by

submission of incurred medical expenses not covered by Medicare, others insurance or

the QMB Buy-in.

Spend-down Eligibility Procedures

Although Medicare may notify the recipient that these Buy-in services are covered services, the fact of the person's Buy-in status is sufficient evidence that these expenses are not obligations of

the recipient and, therefore, may not be deducted from excess income.

A Medicare beneficiary is routinely notified of the results of all claims submitted on his/her

behalf. The notice is called the Medicare Summary Notice form which is issued by a State's

348

Medicare carriers). In Maryland the carrier(s) are as follows:

Novitas Solutions, Inc. Address: PO Box 890385

Camp Hill, PA 17089-0385

Phone: 1-877-235-8073

The notice includes a full explanation of what Medicare was billed for, what was paid, what was not paid and whether the provider accepted the Medicare reimbursement as payment in full. If the provider billed for a higher rate than Medicare pays, and the provider does not accept the Medicare reimbursement as payment in full, the Medicare Summary Notice will include the fact that the beneficiary is responsible for the difference between the amount that Medicare actually paid and the actual charges. However, since the Medicare Beneficiary is enrolled in the Buy-in coverage, local departments will disregard that information for spend-down purposes with the exception that follows, assuming the beneficiary does not have a Medicare supplemental policy such as Blue Shield.

The remaining amount owed for services other than an inpatient hospital bill may be applied to excess income if the provider has billed the MA Program and the Program has refused payment because the Program will not pay for services in excess of what Medicare has paid. In this instance, the additional charges may be applied to excess income for spend-down purposes.

(j) Dually Eligible Persons

Medicare beneficiaries who are eligible for MA are also eligible for the Buy-In coverage concurrent with their MA eligibility. This group is referred to as <u>dually eligible</u>. The Medical Care Operations Administration (MCOA) will, on the basis of the reported Medicare coverage, imprint QMB on the Medicare beneficiary MA card. No additional action for the Buy-in coverage is required of the local department for the initial certification.

The Buy-in coverage has been, in the past, a regular part of MA coverage for Medicare beneficiaries who qualify for MA. That coverage will continue. The single difference is that under the new law, Federal Financial Participation (FFP) is available to the State for the payment of the Medicare Buy-in premiums, whereas, currently, the total premium is paid from state general funds. As a result of the availability of FFP, MA eligible persons must be certified for the Buy-in Coverage.

(k) Specified Low-Income Medicare Beneficiaries (SLMB)

In 1993, the Specified Low-Income Medicare Beneficiaries became effective with only one income standard. SLMB is a person:

- Who is entitled to Medicare hospital benefits under Part A;
- Who is not otherwise eligible for MA due to excess income or resources;
- Whose resources do not exceed the QMB resource limit, and;
- Whose countable income exceeds 100% of Federal Poverty level but does not exceed 120% of the Federal poverty level.

SLMB Eligibility Criteria

- Must meet technical requirements for Medical assistance, (such as filing an application, enumeration, citizenship, identity, residency, assignment of rights, etc.).
- The ABD rules apply to SLMBs.
- Must meet the other requirements for QMB.
- When determining resource eligibility for SLMB, CM should use the QMB resource standard.
- SLMB eligibility is determined only after a person has applied for MA and QMB and has been determined ineligible for both.
- The income standard is higher. It requires that income not only be at or below 120% of poverty, but that it also be greater than 100% of poverty.

Application

SLMB only pays the premium; deductable and co pays are not covered.

- Call local department of social services and request an application for QMB/SLMB.
- Fill out the packet the mail-in application.
- A person may not apply for **SLMB only.**
- Return the application to your nearest LDSS.

The LDSS/LHD numbers are on the last page of the document for customers to keep for their records.

When customers mail form, they are requesting QMB or SLMB benefits through the Maryland MA Program. Once they are found eligible, <u>each year</u> the LDSS/LHD will mail the customer a case information form (CIF) to be reviewed and returned so the customer eligibility for continued QMB/SLMB benefits can be redetermined.

Certification

SLMB eligibility starts at the beginning of the month of the application. Regarding retroeligibility, it starts in the earlier retro month and extends for a 12 month period. Scheduled redeterminations are required every 12 months. If you are eligible for SLMB, you will pay only your monthly Medicare Part B medical insurance premium. You will receive a letter in the mail telling you if you are eligible, but you will not receive a card.

The MMIS-II is unable to manage this Medicaid information; therefore another system has been developed. SLMB certifications will be made via CARES; however, this data will be maintained on a personal computer file instead of MMIS-II.

The following procedures must be used to certify a SLMB

• Unique Case Number Assignment. SLMB will be assigned a unique M.A. case number by the LDSS CM.

- The first two positions will be 96.
- The second two positions will be the county indicator (e.g. Baltimore city=30. Baltimore county=03).
- The next four (4) positions will be a special SLMB case number assigned by DHR/LDSS.
- The last three (3) positions will be the last two digits of the birth year plus a 0 or tie-breaker (e.g. 1950=500).

Spend-down

When spend-down eligibility ends, the recipient must reapply for MA/QMB if SLMB coverage is desired.

Attachment A-2012 Dual Eligible Standards

2012 Dual Eligible Standards

(Based on Percentage of Federal Poverty Level)

Qualified Medicare Beneficiary (QMB):

Monthly Income Limits: $(100\% \text{ FPL} + \$20)^*$

All States and DC (Except Alaska & Hawaii): \$951- Individual \$1,281 - Couple Alaska: \$1,185 - Individual \$1,597 - Couple Hawaii: \$1,092-Individual \$1,471 - Couple

Asset Limits: \$6,940-Individual \$10,410 - Couple

Specified Low-Income Medicare Beneficiary (SLMB):

Monthly Income Limits: $(120\% \text{ FPL} + \$20)^*$

All States and DC (Except Alaska & Hawaii): \$1,137-Individual \$1,533 - Couple Alaska: \$1,417-Individual \$1,912 - Couple Hawaii: \$1,306-Individual \$1,761 - Couple

Asset Limits: \$6,940-Individual \$10,410 - Couple

Qualifying Individual (QI):

Monthly Income Limits: $(135\% \text{ FPL} + \$20)^*$

All States and DC (Except Alaska & Hawaii): \$1,277 - Individual \$1,723 - Couple Alaska: \$1,592 - Individual \$2,149 - Couple \$1,467 - Individual \$1,979 - Couple

Asset Limits: \$6,940 – Individual \$10,410 – Couple

Qualified Disabled Working Individual (QDWI):

Monthly Income Limits: (200% FPL + \$20)* (Includes additional earned income disregards)

All States and DC (Except Alaska & Hawaii): \$3,809 – Individual \$5,129 – Couple Alaska: \$4,742 – Individual \$6,392 – Couple Asset Limits: \$4,372 – Individual \$5,889 – Couple \$4,000 – Individual \$6,000 – Couple

Includes: \$20 = Amount of the Monthly SSI Income Disregard \$1500= Burial Credit

(1) Disabled Adult Children (DAC)

If the Social Security Administration (SSA) considers an individual eligible for Supplemental Security Income (SSI), the individual is eligible for MA as an SSI recipient, even if the individual does not receive SSI cash benefits due to receipt or increase of Social Security benefits. An SSI-eligible person who is at least 18 years old is MA-eligible as a Disabled Adult Child (DAC) if the parent, on whom the individual is dependent, dies or receives Social Security benefits as an elderly or disabled person, and the SSI recipient files a claim for Social Security benefits based on the parent's Social Security account. If the individual's Social Security cash benefit exceeds the SSI benefit, the individual no longer receives SSI cash payments. The individual must be "deemed" by SSA as SSI-eligible in a no-pay status. This sequence of events makes the individual a DAC. Since the individual is still SSI eligible, he/she remains MA-eligible as such. The DAC does not need to file a MA application in order to obtain and retain MA coverage. The MA does not need to file a MA application in order to obtain and retain MA coverage. The MA eligibility CM must assure that the DAC's MA eligibility remains active without a break after the SSI payments end, and SSI eligibility continues in a no-pay status.

For an individual to be MA-eligible as a DAC, the individual must be "deemed" by SSA as SSI-eligible in a no-pay status. This occurs when the individual becomes income over scale for SSI cash benefits due to receipt or increase of Social Security Childhood Disability Benefits under the parent's Social Security account.

Eligibility criteria must be met for Childhood Disability Benefits:

- The individual is at least 18 years old, unmarried, not the head of a household, and dependent on a parent because the individual is blind or disabled;
- The individual has blindness or a disability that began before age 22; and
- The individual's parent either died or became eligible for Social Security because the parent is elderly or disabled.

The State Data Exchange System (SDX) or State Verification and Exchange System (SVES) should indicate that the SSI recipient is MA-eligible as a DAC when SSI cash payments end or when SSI eligibility is initiated in a no pay status. SDX/SVES should have the following information in order for an individual to be considered a DAC:

DAC Eligibility Criteria

- The individual is at least 18 years old;
- The individual has "D" (deemed) as the SSI status for Medicaid eligibility;
- The individual has "NCI" (no payment) as the SSI payment status;
- The individual's SSA claim number differs from the individuals' Social Security number, because he/she eligible under the parent's SSA claim number;
- The individual's SSA claim number ends with a "C" suffix (Beneficiary Identification Code-BIC), followed by a number (e.g. "212-22-1212 C1).

This information is not always transmitted accurately or timely by SSA. Upon discovering that a DAC was denied or terminated for MA eligibility due to an SDX or CM error, the CM must certify the individual as MA-eligible retroactive to the date that MA eligibility was erroneously denied or terminated.

Anyone who meets the DAC criteria must be certified as eligible for MA without a lapse in coverage from the time that SSI cash payments ended. Even though a DAC may have income in excess of the MA medically needy income limit (MNIL), the individual is eligible as a DAC. They are not required to complete a MA application form. A financial eligibility determination is not conducted.

Eligibility Upon Employment

If a DAC becomes employed, the earned income or accumulated resources may make the individual financially ineligible for the deemed status of SSI eligibility. When SSA's database indicates that a DAC is no longer SSI-eligible, the individual is no longer categorically eligible for MA as an SSI recipient. The MA eligibility CM must then redetermine the individual's eligibility for the most appropriate coverage group. The policies and procedures followed in section 12 and its CARES supplement for "Redeterminations for Former SSI recipients." Eligibility must be redetermined before MA coverage may be terminated, with a notice of adverse action issued at least 10 days before any closure.

Although a DAC may have received SSI benefits as a child, this is not a requirement. An individual is eligible for SSI payments as a child if the individual:

Qualifies for SSI based on disability and financial eligibility is either:

- Under 18 years old, or
- Under 22 years old and regularly attending school, college, or training that was designed to prepare the individual for a paying job;
- Is not married: and
- Is not the head of household

CARES Procedures

- The following procedures are used to certify a DAC as eligible in coverage group S02 on CARES:
- Delete the SSI income from the UINC screen effective the month that the SSI payments ended. Enter the SSA income effective the month that the Social Security payments began. (These months should be the same.)
- At the bottom of the UINC screen, enter "SI" in the "Appl type" field, and enter "S" in the "Stat" field, Enter the date the SSI cash payments were terminated.

• SSI eligibility has not been closed yet, these changes may be entered as interim changes. If SSI eligibility has already been terminated, the case will need to be rescreened, and these changes entered before finalization.

(m) Disabled Widowed Beneficiaries (DWB)

A widow or widower who receives SSI based on his or her own disability, but is later found to be eligible for Social Security benefits based on the account of the deceased spouse, is referred to as a disabled widowed beneficiary (DWB). These persons may also be referred to as "Kennelly Widows." The SSA benefit is generally greater than the SSI benefit, resulting in the DWB's loss of SSI eligibility. Even though the DWB no longer receives an SSI payment, he/she is deemed eligible for MA as an SSI recipient.

DWB Eligibility Criteria

- The person is a former SSI recipient;
- The person is not yet 65 years old;
- The person is ineligible for Medicare;
- The person's SSA claim number is the Social Security number of the deceased spouse.

Certifications

Anyone who meets all of these criteria may be certified. These persons are required to file an application. Resources may not exceed the SSI resource standard of \$2000; however, even if income exceeds the MNIL they are still considered CN.

CARES Procedures

In a non-CARES jurisdiction, certify a SWB as category 06. In a CARES jurisdiction, the DWB is in coverage group S02. Delete the SSI income from the UINC screen effective the month it terminated; enter the SSA income effective the month it began (these should be the same months). On the bottom of the UINC screen enter "SI" in the "Appl type" field, and "S" in the "Stat" field. Enter the date SSI was terminated. If the SSI case has not yet been closed, these changes may be entered as interim changes. If the SSI eligibility has already been terminated, the case will need to be rescreened, matched and the changes entered before finalization.

(n) Qualified Disabled and Working Individuals (QDWI) Coverage Group (S06)

Non-elderly persons who are entitled to Medicare Part A (Hospital Insurance) by reason of their disability, but who are not eligible to receive a Social Security benefit because they are employed, may be eligible for federally matched MA coverage of their Medicare Part A premiums if their income is at or below 200% of the federal poverty level and their resources do not exceed twice the SSI standard. A card is not issued for QDWI recipients since the benefit does not cover any medical expenses just the Medicare Part A premium.

QDWI Eligibility Criteria

The A/R must have been entitled to Medicare Part A while eligible for Social Security disability benefits and have lost eligibility because he/she is working. The individual must continue to be considered disabled by the SSA. The age range for QDWI eligibility is 21-64 years old.

- The applicant should be tested under ABD regulations. Eligibility as a QDWI is based on the disabled individual losing Social Security benefits due to employment. If the person is married, the income and resources of the spouse are considered, even though the AU only includes the QDWI eligible person.
- The income considered available to the A/R may not exceed 200% of the FPL for the household size (one or two persons if there is a spouse).
- The resources considered available to the A/R may not exceed twice the maximum standard for Supplemental Security Income (SSI). Since the current SSI resource standard is \$2,000.00, the maximum allowable resources for QDWI eligibility are \$4,000.00 for one person and \$6,000.00 for a couple. This is the same resource standard used for QMB/SLMB; however, the income limit is different.
- To be eligible for QDWI, the applicant/recipient may not be active in any other Medicaid coverage group When a person active as a QDWI (S06) applies for more comprehensive Medicaid benefits during the certification period and is determined eligible in another coverage group, the S06 case must be closed in conjunction with opening the new case to avoid dual participation in CARES. The Case Manager must establish a 745 Alert for the end of the new MA certification period, as reminder to review for the S06 eligibility. If the individual loses eligibility for the higher Medicaid coverage group, the Case Manager should follow current redetermination procedures in the MA Manual, Chapter 12, including consideration as a QDWI. Verify that the QDWI status still applies, using SOLQ/SVES)
- The A/R must meet the technical Medicaid requirements in COMAR 10.09.24.04 and .05. Since these individuals must still be considered disabled by SSA, they will not receive a disability determination by the State Review Team (SRT). Disability status must be verified on SOLQ/SVES. Use this information to complete the CARES DEM2 screen Disability Fields
- Income and resources are considered according to the requirements in COMAR 10.09.24 for a non-institutionalized aged, blind or disabled person. (NOTE: A person becomes entitled free Medicare Part A when he or she attains age 65 and is considered aged.)
- The QDWI coverage group does NOT provide for any retroactive coverage prior to the month of application

Application

• Individuals must apply for this Medicaid benefit at the LDSS. Eligibility for this program is not granted automatically. It is based on a letter from SSA to the person indicating potential eligibility. The CM must still use SOLQ/SVES to verify the eligibility status. Once the

- eligibility determinations are finished and the S06 is finalized, suppress all CARES notices on the MAFI screen for the S98 (unless eligible), S99, and S06 cases and send the appropriate attached manual notice.
- If pending the S06 case would cause it to exceed the 30 day period for making an eligibility determination, determine the S06 case and take the appropriate action when eligibility is determination, determine the S06 case take the appropriate action when eligibility is determined for the original pending case (e.g. closing the S06 case and opening an S99 case).
- The CARES 9701 application is used by the LDSS for these applicants.
- The applicant should be tested for eligibility in both S98 and S06. Pend both at the same time.
- The applicant should have a letter from SSA indicating the QDWI status, but a copy of this letter is not required. The CM must verify that the individual is potentially QDWI eligible per SSA by having a "Current Pay Status" of N33 or N44 on SVES. The disability coding on SVES must also be reviewed to determine whether the person is still considered disabled by SSA. If these individuals have a 'Current Pay Status" code N27 on SVES indicating that they are no longer considered disabled by SSA, they are not eligible as a QDWI. The N27 ineligibility code on SVES is changed by the SSA system to a termination code after one year.
- Persons may apply for QDWI in the same month as their SSA notification that they are no longer entitled to Medicare Part A. Individuals who do not apply for QDWI within 7 months of the SSA notice will have to wait until next Medicare open enrollment period (January 1-March 31) for the federal government to approve their Buy-In coverage, and then the State's payments may not begin until July 1. If the delay in applying, they may also be required by SSA to pay a premium surcharge, unless they are covered by an employee group health plan based on their own or their spouse's current employment. The QDWI eligible is personally responsible for any surcharge(s) because the State will not pay a premium surcharge
- The UINC screen must be properly coded with the A/R's SSA claim number and BIC, and completed with the unearned income fields, and Application Type, etc. fields at the bottom of the screen. The termination date for previous benefits must be entered to indicate the termination of a prior period of SSA eligibility.
- The application must be processed within a 30 day period. If there is a delay reason, place the appropriate delay code on the CARES MISC screen.
- The CARES notice for approval or denial of the application must be suppressed by the Case Manager, and the appropriate approval or denial notice (see attachments) must be completed and issued manually. Any closing notice to a recipient must also be suppressed on CARES, and a QDWI closing notice (see attachment) completed and issued manually.

Coverage

The federal government approves the effective date for the State's payment of Medicare Part A for QDWI, based on the date of the SSA eligibility letter and when the individual applies for QDWI at the LDSS. The effective (begin) date of S06 eligibility will not necessarily be the 1st day of the month of application. The Centers of Medicare and Medicaid Services (CMS) will advise the DHMH Buy- In Unit of the effective date. The Buy-In Unit will inform the LDSS Case Manager if the effective date on CARES for S06 eligibility needs to be changed through an unscheduled redetermination.

Procedures

Once the CM has determinate that the A/R is eligible for QDWI benefits, the eligibility date should begin the same month as the date of the application. The case should be certified for a year and have a yearly redetermination.

- When the CM is notified by the DHMH Buy-In Unit of the premium begin date, the CM must initiate an unscheduled redetermination to reset the effective date for a new 12 month certification period. A new application is not necessary because all eligibility factors remain the same.
 - Complete the redetermination, which will reset the certification period forward 12 months. If for some reason the redetermination end date needs to be modified, shorten the redetermination end date as necessary to coincide with the begin date of premium payments. Suppress the CARES notices, and send manual QDWI notices to include the date the State will begin paying the Medicare Part A premium.
 - A person must be under 65 years old to be eligible in this coverage group. The month before the customer turns 65, the CM will receive a CARES Alert (216). CARES will close the S06 AU at the end of the month in which the client turns age 65. As with all other MA coverage groups, the customer must be tested for MA eligibility in accordance with federal guidelines for delinking.
 - An individual who turns 65 year old during the consideration period must be determined for QDWI eligibility for any months prior to the attainment of 65. When the appropriate eligibility is determined and the notice sent advising the individual of the determination, the CM must also include a statement that they are not eligible once they reach age 65 because they are "potentially" eligible for free Medicare Part A. Also, they should contact SSA if they have not already been notified of this eligibility
 CMS will notify the DHMH Buy-In Unit when a person reaches 65 years old and the State's payment of the Medicare Part A premium is no longer due. The Buy-In Unit will then have the S06 case closed on MMIS effective the last day of the month of entitlement to S06 coverage. The Buy-In Unit will provide the information to the LDSS CM. The CM then must close the case

on CARES (if it has not been closed already), suppress the CARES notice, and send a manual QDWI notice (see attached notice).

- The QDWI coverage group does not cover the premium for Medicare Part B. The individual may elect to participate in Part B and pay the Part B premium to SSA
- There are annual redeterminations for coverage group S06 because there is 12 month certification period. CARES should issue the redetermination package on schedule. SVES must be reviewed to determine if the person still meets the criteria for QDWI eligibility. All Medicaid redetermination requirements in COMAR 10.09.24.12 must be met. If eligibility as a QDWI is terminated, the CM must determine if the individual is eligible for any other Medicaid coverage group.

Termination of Premium HI (Medicare Part A) and QDWI Eligibility

- Premium- HI for the working Disabled continue until the earliest of;
 - The end of the month the following the month the individual is notified by SSA that he or she no longer has a disabling impairment. (This can be verified on SVES as "Current Pay Status" N27.)
 - The end of the month following the month the individual files a request for termination of Premium HI.
 - The end of the month the individual becomes re-entitled to premium free HI or turns age 65.
 - o The date of death.
- The individual must receive a notice of the termination at least 10 days before the effective date, including appeal rights. The CARES notice must be suppressed, and a QDWI termination notice muse be issued manually by the CM (see attached notice).

CARES Screens/Procedures

Follow the general CARES procedures for processing an application for Community MA as ABD. The instructions below are to assist with additional steps or information necessary in relation to the S06 Medicaid Coverage Group.

The applicant should be tested for eligibility in both S98 and S06. Pend both at the same time. The eligibility for S98 should be tested first.

- If the customer is active ("A" status, not "M" status on the STAT Screen in CARES) in S98 or S99 coverage; finalize the AU for the Active S98 or S99 coverage group and allow the CARES notices eligibility coverage group. Suppress the CARES notice for denial of S06.
- If the countable income causes the S98 AU to go into a preserved status for spend-down ("M" status), DO NOT FINALIZE the S98 case (using reason code "550") to prevent it from trickling to preserved "M" status for S99. CARES does

- not permit dual participation for the S06 coverage group. Suppress the CARES notice.
- If the applicant is not eligible for S06, allow CARES to deny the S06 AU, suppress the CARES notice, and send the manual QDWI denial notice. Next, finalize the S98 case to allow tricking to S99, and allow all CARES notices to be sent for the S AU.

Screening (Option J)

• In screening on the CIRC screen- place a "Y" in the disabled field (this is to insure the selection of the medical coverage group S98). On the INCH screen, select the MA coverage group S98, and add MA coverage group S06. The MA Coverage Type should a "D" for Disabled or a "B" for Blind. (It should not be an "A' because aged individuals don not qualify for this program.)

Interview (Option O)

- During the interview option, the CM will need specific information from a SOLQ/SVES inquiry in order to complete the Disability/Incapacity Fields on the DEM2 screen.
- In order to be eligible for S06 MA Coverage, the customer must have been receiving SA benefits due to disability and must still be considered by SSA as disabled. Therefore, the Disability/Incapacity Fields must be completed on the DEM2 screen in CARES. If the AU was screened property with a "D" or "B" as the MA Type of the INCH screen, the required fields will be marked with asterisks during the Interview Option on the DEM2 screen.

DEM2 Screen

- If the S06 case has the MA Type Code of "D" for Disabled or "B" for Blind, the following should be entered on the DEM2 in the correlated fields;
 - o Disab/Incap Field= "O" for Other Disease if disabled or "K" for Visual Impaired if blind
 - o Disability/Incapacity Approval Source= "RS" for SSA Disability Approval
 - Disability/Incapacity Approval Date (MM/YY)= the date of disability determined by SSA from the SOLA inquiry
 - o Disability/Incapacity Began Date (MM/YY)= the same as the Approval Date
 - Disability/Incapacity End Date (MM/YY)= since this is indeterminate, enter 99/99 in this field.
 - Entitle Med A Field= "T" for Terminated (This valid value works correctly in CARES, but is not currently listed as a useable valid value in the Help text.
 Updating of the Help text has AU will deny for no eligible members and for failing the age requirement.

ERN1 and **ERN2** Screens

• In order for a customer to be eligible for S06 QDWI, the customer must be Employed. Therefore, the CM should have earnings information to key onto ERN1 and ERN2 screens in CARES, following the general procedures.

UINC Screen

- This screen is not required to process the AU eligibility on CARES. However, a SSA Claim Number with the proper BIC must be entered on the UNIC screen in order to transmit the Medicare number to DHMH.
- In the claim number Fields:
 - Enter the Social Security claim number
- In the BIC Fields:
 - o Enter the BIC associated with the A/R claim number
- In the Unearned Income field and In the Social field:
 - o Enter "SA" for a Social Security benefit or "RR" for a Railroad benefit
- In the Amount Field:
 - Enter \$1.00
- Complete all other required fields
- The application Type, State, and Date fields must be completed at the bottom of the screen.
- In the Appl Type:
 - o Enter "SA"
- In the State Field:
 - o Enter 'T" for termination
- In the Date field:
 - o Enter the end date of the SSA eligibility

NOTE: The CM should remember that if the eligibility is ever overscale by \$1, they will need to view the income and adjust it accordingly by deducting \$1 to offset the \$1 entered on the UINC screen.

Unscheduled Redeterminations

When notification is received that CMS had approved State payment of premium payment for Medicare Part A, an unscheduled redetermination is necessary to reset the effective date for a new 12- month certification period. A new application is not necessary, because all eligibility factors remain the same. Upon notification of the effective premium payment date, the CM is to initiate a redetermination by selecting option "N" (initiate Redet) from the AMEN screen on CARES. Select option "R" and complete all necessary eligibility requirements to maintain eligibility. On the MAFI screen, review the Redet End Date to ensure the proper certification

period. The redetermination end date should be 12 months from the begin payment confirmed by CMS. Confirm eligibility and suppress all notices and send the manual QDWI notice. (see attached.)

Notices

Suppress ALL CARES notices and send manual notices instead, unless the A/R is approved for S98 eligibility. CARES will automatically generate a closing notice for individuals when they reach age 65. See attached QDWI notices.

Maryland Medical Assistance Program Notice of Eligibility for Medicare Hospital Insurance (Part A) Buy-In Only As a Qualified Disabled Working Individual

	Date:
	Customer ID: District:
Dear :	
This is to notify you that based on the application you filed on payment of your Medicare Part A Hospital Insurance premiums. After the federa State will begin paying your Medicare Part A premiums. The State will issue pa payments will continue until you are notified that you are no longer eligible.	al government determines the effective date, you will be informed when the
You will not receive a Maryland Medical Care Program card because yo eligible for Medical Assistance (Medicaid) to cover medical services.	u are just eligible for coverage of Medicare Part A premiums. You are not
You should continue to pay the monthly premium for Medicare Part A u premiums for you. If you pay for the same month that the State pays, the Social determines that you must pay a surcharge, besides your regular premium, you are surcharges. If you elect to participate in Medicare Part B, you are responsible fo	e responsible for payment of the surcharge. The State does not pay any
You will be required to re-establish your eligibility for this coverage at advance of the due date. The necessary instructions and forms will be mailed to	1
You must notify this agency of any changes in your situation such as em telephone number. Any of these changes could affect your eligibility. You must at the telephone number below. If you have any questions about this notice, you	
	Sincerely,
	Case Manager
	Telephone

COMAR 10.09.24.03

Summary of Procedures for Fair Hearings

You have the right to appeal this decision within 90 days from the date of this notice. Your request must be made in writing on a form you may

obtain from your Case Manager. Please include the specific reason(s) for your appeal. If you wish, someone at the local department of social services may

assist you in completing the form for filing your appeal. Bring the form to your local department of social services office, or you may mail your request for

a hearing to the following address:

Office of Administrative Hearings

Administrative Law Building

11101 Gilroy Road

Hunt Valley, Maryland 21031-1301

The hearing will be scheduled at a time and place that are convenient for you. You will be expected to be present. If for any reason you cannot

be present, you must notify the Office of Administrative Hearing to reschedule the hearing or to identify the person who will attend in your place. You may

represent yourself, or if you wish you may be represented by legal counsel or by a relative, friend or other person, although it is not required that someone

represent you. You may bring any witnesses you desire to help you establish pertinent facts and to explain your circumstances. A reasonable number of

persons from the general public may be admitted to the hearing if you so desire.

You may obtain free legal aid and help through various resources, such as the Legal Aid Bureau at 1-800-999-8904.

364

Maryland Medical Assistance Program

Notice of Eligibility for Medicare Hospital Insurance (Part A) Buy-In Only As a Qualified Disabled Working Individual

	Date: Customer ID: District:
Dear:	
	you filed on, we have determined that you are eligible for State ms. The federal government has determined that the effective date for the State to start making
back for those months. If the federal government determine any surcharge. The State does not pay any surcharges. If ye	A premiums that the State will now pay, the U.S. Social Security Administration will pay you that you must pay a surcharge, besides the regular premium, you are responsible for payment u elect to participate in Medicare Part B, you are responsible for paying the premium to the Health and Mental Hygiene's Buy-In Unit at 1-800-638-3403 if you have any questions about
Contact your Case Manager at the telephone num	ber below, if you have any questions about this notice or your eligibility.
	Sincerely,
	Case Manager

Telephone

COMAR 10.09.24.03

Summary of Procedures for Fair Hearings

You have the right to appeal this decision within 90 days from the date of this notice. Your request must be made in writing on a form you may

obtain from your Case Manager. Please include the specific reason(s) for your appeal. If you wish, someone at the local department of social services may

assist you in completing the form for filing your appeal. Bring the form to your local department of social services office, or you may mail your request for

a hearing to the following address:

Office of Administrative Hearings

Administrative Law Building

11101 Gilroy Road

Hunt Valley, Maryland 21031-1301

The hearing will be scheduled at a time and place that are convenient for you. You will be expected to be present. If for any reason you cannot

be present, you must notify the Office of Administrative Hearing to reschedule the hearing or to identify the person who will attend in your place. You may

represent yourself, or if you wish you may be represented by legal counsel or by a relative, friend or other person, although it is not required that someone

represent you. You may bring any witnesses you desire to help you establish pertinent facts and to explain your circumstances. A reasonable number of

persons from the general public may be admitted to the hearing if you so desire.

You may obtain free legal aid and help through various resources, such as the Legal Aid Bureau at 1-800-999-8904.

366

Maryland Medical Assistance Program Notice of Eligibility for Medicare Hospital Insurance (Part A) Buy-In Only As a Qualified Disabled Working Individual

	Date:
	Customer ID:
	District:
	
Dear:	
Based on the application you filed on, you ar	re not eligible for Medical Assistance coverage of health care services or for
State payment of your Medicare Part A Hospital Insurance premium. You are n	not eligible for the following reason(s):
1. You did not provide the information necessary to complete your eligibility	
10 11 41 10 21 10	'11
	, you will not have to file another application form. This agency will
re-activate your original application and determine your eligib	iiity.
2. Your income exceeds the maximum allowable amount of:	
Income Standards	
income Standards	
Medical Assistance Qualifi	ied Disabled Working Individual
	ica Disablea Working individual
Ψ	
The type and amount of income counted is listed below:	
21	\$
	\$
	\$
The amount of income deducted is:	
	\$
	\$
	\$
The total amount of your countable income is:	\$
☐ 3. Your assets exceed the maximum allowable amount of:	
Asset Stand	lards
Medical Assistance	Qualified Disabled Working Individual
\$	\$
m	
The assets counted are listed below:	
	¢
	\$ \$
	\$
	\$
The total amount of your countable assets is:	\$
	367

COMAR 10.09.24.03

You should reapply when your income and/or assets no longer exceed the maximum allowable amount.				
4. You do not meet the following eligibility requirements:				
	curity Act [1902(a)(10)(E)(ii),1905(p)(3)(A)(I)]. If you do not agree with this decision, yo f the date of this notice. If you have any questions about this notice, you may contact your			
	Sincerely,			
	Case Manager			
	Telephone			

COMAR 10.09.24.03

Summary of Procedures for Fair Hearings

You have the right to appeal this decision within 90 days from the date of this notice. Your request must be made in writing on a form you may

obtain from your Case Manager. Please include the specific reason(s) for your appeal. If you wish, someone at the local department of social services may

assist you in completing the form for filing your appeal. Bring the form to your local department of social services office, or you may mail your request for

a hearing to the following address:

Office of Administrative Hearings

Administrative Law Building

11101 Gilroy Road

Hunt Valley, Maryland 21031-1301

The hearing will be scheduled at a time and place that are convenient for you. You will be expected to be present. If for any reason you cannot

be present, you must notify the Office of Administrative Hearing to reschedule the hearing or to identify the person who will attend in your place. You may

represent yourself, or if you wish you may be represented by legal counsel or by a relative, friend or other person, although it is not required that someone

represent you. You may bring any witnesses you desire to help you establish pertinent facts and to explain your circumstances. A reasonable number of

persons from the general public may be admitted to the hearing if you so desire.

You may obtain free legal aid and help through various resources, such as the Legal Aid Bureau at 1-800-999-8904.

369

Maryland Medical Assistance Program Notice of Eligibility for Medicare Hospital Insurance (Part A) Buy-In Only As a Qualified Disabled Working Individual

		Date:
		Customer ID:
		District:
		
		
Dea	ear:	
	It has been determined that you are no longer eligible as of	for the State's payment of your
Иe	edicare Part A Hospital Insurance premium.	
	1	
	This determination is based on the following reasons:	
	·	
	1. You no longer meet the following eligibility requirements:	
	2. You failed to complete the redetermination process. Your eligibility with the redetermination package or a new application with your Case Mana	ill be considered and may be re-established without a gap in coverage if you file ager by
	3. You failed to provide the requested information needed to determine yo	our continued eligibility. The information required is:
	If you send this information to your Case Manager before application. This agency will re-activate your original redetermination	, you will not have to file another redetermination application and determine your continued eligibility for State payment of the
	Medicare Part A premium.	
	 You or your authorized representative declined to continue to participa Disabled Working Individual. 	te in the Medicare Part A Hospital Insurance Buy-In Program as a Qualified
	5. Other reason(s)	
	This decision is based on COMAD10.00.24 and/on the Social Security	with Act [1002(a)(10)(E)(ii) 1005(n)(2)(A)(I)]. If you do not come with this
		rity Act [1902(a)(10)(E)(ii), 1905(p)(3)(A)(I)]. If you do not agree with this
		lays of the date of this notice. If you have any questions about this notice, you
	may contact your Case Manager at the telephone number below.	
		Sincerely,
		Sincerery,
		Casa Managar
		Case Manager
		Talanhana

Summary of Procedures for Fair Hearings

You have the right to appeal this decision within 90 days from the date of this notice. Your request must be made in writing on a form you may obtain from your Case Manager. Please include the specific reason(s) for your appeal. If you wish, someone at the local department of social services may assist you in completing the form for filing your appeal. Bring the form to your local department of social services office, or you may mail your request for a hearing to the following address:

Office of Administrative Hearings Administrative Law Building 11101 Gilroy Road Hunt Valley, Maryland 21031-1301

The hearing will be scheduled at a time and place that are convenient for you. You will be expected to be present. If for any reason you cannot be present, you must notify the Office of Administrative Hearing to reschedule the hearing or to identify the person who will attend in your place. You may represent yourself, or if you wish you may be represented by legal counsel or by a relative, friend or other person, although it is not required that someone represent you. You may bring any witnesses you desire to help you establish pertinent facts and to explain your circumstances. A reasonable number of persons from the general public may be admitted to the hearing if you so desire.

You may obtain free legal aid and help through various resources, such as the Legal Aid Bureau at 1-800-999-8904.

(o) Family Planning Program

Effective January 1, 2012, The DHMH has expanded the current MA Family Planning Program (FP). Medicaid will cover family planning services for low income women under the age of 51 in addition to the current postpartum women.

What is Family Planning (FP) Program?

Provides family planning benefits for certain low income eligible women. Applicant must be under 51 years of age, a Maryland resident, and a U.S. citizen or a qualified alien who meets all requirements for benefits. The FP is a fee- for service program and recipients will not be enrolled in a MCO's.

FP Eligibility Criteria:

- A U.S. citizen or qualified alien
- A Maryland resident
- Female, under 51 years of age who;
 - Is not pregnant
 - Has not had a permanent sterilization
- An applicant must also have household income that does not exceed 200% of the Federal Poverty Level.
- Women who already have MA are not eligible for this program

Family Planning Benefit Coverage

- Visit to the doctor or clinic
- Pelvic exams, pap smears, and screenings for Sexually Transmitted Infection (STI's) and HIV(Human immunodeficiency virus) as part of annual visit
- Consultation about birth control methods
- Prescriptions and devices for birth control
- Permanent sterilization (must be over 21)

NOTE: Eligibility Determination, The FP eligibility staff at DHMH will determine eligibility and notify applicants of the eligibility decision by mail.

(p) Children and Temporary Cash Assistance (TCA) adults in Long-Term Care Facilities (LTCF)

The T- Track for Family LTC is used for MA eligibility determinations for children and certain adults admitted to a LTCF. The T-track is different from the L-Track, which is for ABD in LTC. The T-Track is for children and adults whose MA LTC eligibility is determined using the eligibility policy for:

- FAC under COMAR 10.09.24- Medical assistance Eligibility; or
- Children under COMAR 10.09.11-Maryland Children's Health Program (MCHP), but not including MCHP coverage under Title XXI of the Social Security Act (coverage groups P13 and P14 and the D-Track.

When a child (under 21 years old) is admitted to a LTCF, MA LTC eligibility is determined for the T-Track. If the child is currently MA community eligible (E, F, G, H, or S track) or MCHP eligible (P-Track), an unscheduled redetermination is necessary. If the child is not an active MA or MCHP recipient, an initial MA LTC eligibility determination is conducted. The L-Track is only used for a child who is a recipient of Supplemental Security Income (SSI) or whose LTC eligibility is determined using ABD rules. All SSI recipients, adults or children, who have no other source of income, have their LTC eligibility determined for coverage group L01, so they are not subject to annual redeterminations (see Policy Alert 10-08).

When a child, parent, or caretaker relative, who is active in MA community coverage group F01 due to receipt of TCA, is admitted to a LTCF, MA LTC eligibility may be determined for the T-Track coverage group T01. Then, the recipient does have to be determined as aged, blind, or disabled in the L-Track in order to be covered by MA for LTC services.

Note: The information below provide local offices uniform policies and procedures to be followed when determining LTC eligibility in the T-Track for a child or a TCA adult.

Eligibility Policy-Coverage Groups in the T-Track for Children or TCA Adults in Long-Term Care

Following is a description of the basic eligibility for policy for the T-track. For all individuals being determined for T-track eligibility:

- Eligibility is determined by LTC MA CM at the LDSS's. However, a Financial Agent or a MA CM at the Division of Eligibility Waiver Services (DEWS) determines MA LTC eligibility for seriously mentally ill or emotionally disturbed children who are admitted to an Institution for Mental Disease (IMD), Regional Institute for Children and Adolescents (RICA), or Residential Treatment Center (RTC).
- The applicant/recipient (A/R) is considered a household of one person, since the child is an out-of-home placement.
 - Children who are active in coverage groups S02 for SSI recipients, or who are
 revealed by clearances using SVES/SDX/SQLQ to be receiving SSI, should have
 their LTC eligibility determined in coverage group L01 if they have no income
 besides SSI, the same as adult SSI recipients admitted to LTCFs.
 - The DHR/FIA CARES 9708 is used as the MA application form for a children A/R. If the A/R is considered an adult, the DHR/FIA CARS 9709 is used.
 - As with the L-track, The T-track requires a DHMH 257 before MA LTC eligibility may be determined. The State's Utilization Control Agent must certify that the child needs the level of care provided by the LTCG.
 - A child is considered institutationalized as of the 1st day of the first full calendar month in the LTCF. However, an adult is considered institutionalized as of the 30th consecutive day in hospital or by transfer to a different LTCF. i.e. A child who is 10 years old and active coverage group P08 enters a LTCF on 7/15. The child is an acute hospital 8/2-8/8, then returns to the LTCF and is there as of the end of August. Eligibility is determined for T05. P08 eligibility ends as of 7/31. T05 eligibility and the LTC span begin as of 8/1.
 - When a MA or MCHP recipient is admitted to the LTCF, the community-based eligibility continues and the services in the LTCF are paid until the recipient is considered to be institutionalized. Then, a MA LTC eligibility determination is necessary in order of MA to cover the LTC services. If the recipient is enrolled in the HealthChoice when admitted to the LTCF, the MCO or the Mental Hygiene Administration for recipient admitted to a (Residential Treatment Center or other psychiatric facility) covers the authorized care in the LTCF while the recipient is considered a community MA or MCHP recipient.

- If a MA or MCHP community recipient is admitted to a LTCF for a less than 30-day stay follow procedures in the MA Eligibility Manual.
- If a MA or MCHP community recipient is covered by Medicare for skilled or chronic care in a LTCF, follow the policies and procedures in the MA Eligibility Manual.
- The MA LTC post-eligibility policies and procedures related to spousal impoverishment and calculation of the available income towards the cost of care are applied to recipients determined eligible in the T-track. These policies and procedures are specified in Chapter 10 of the MA Eligibility Manual and in COMAR 10.09.24.10 and 10-1.
- For recipients eligible in the T-track, MA pays the portion of the facility's cost of
 care that exceeds the recipient's available income, and also covers all the MA
 services for which the recipient qualifies.

Family Long-Term-Care T-Track

T01 TCA Adult or Child in Long-Term-Care

When a child or adult who receives TCA under TANF Section 1931 (F01 coverage group) is placed in a LTCF, MA will pay the cost of care in the facility and cover other MA services for which the recipient is eligible. The TCA financial and non-financial eligibility requirements are specified in COMAR 07.03.03 and the TCA manual, established by the DHR.

T02 FAC Long-Term-Care-Medically Needy

MA is provided for an unmarried child under 21 years old in a LTCF, if the child's resource do not exceed the medically needy resource standard (no more than \$2,500 in countable resources, after subtracting exclusions) and if the child's countable net income (after subtracting exclusions and disregards) is insufficient to pay the LTCF's cost of care. These are the same LTC medically needy income and resource standards used for coverage group L98- ABD persons in LTC. However, the T02 coverage groups uses the FAC rules in COMAR 10.09.24.07 and .08 and Chapters 7 and 8 of the MA Eligibility Manual for the income and resource exclusions and the income disregards.

T03 Child Under 1 Year Old in Long Term Care

MA is provided for a child under 1 year old who resides in a LTCF. The financial and non-financial eligibility rules for P06 are used, as specified in COMAR 10.09.11 and the MCHP Eligibility Manual. The child's income must be at or below 185% of the federal poverty level (FPL). There is no resources test.

T04 Child from 1 Year Old Up to 6 Years Old in Long -Term-Care

MA is provided for a child who is at least one year old but less than six years old who resides in a LTCF. The financial and non-financial eligibility rules for P07 are used, as specified in COMAR 10.09.11 and the MCHP Eligibility Manual. The child's income must be at or below 133% of the FPL. There is no resource test.

T05 Child Under 19 Years Old in Long-Term-Care

MA is provided for a child under 19 years old who resides in a LTCF. The financial and non-financial eligibility rules for P08 are used, as specified in COMAR 10.09.11 and the MCHP Eligibility Manual. The child's income must be at below 100% of the FPL. There is no resource test.

T99 FAC Long- Term- Care- Medically Needy Spend-down

Unmarried children under 21 years old in a LTCF who resources do not exceed the MN resource standards (\$2,500), but whose available income exceeds the cost of care in the facility, are eligible for MA if the child's total medical expenses are greater than the amount by which the child's income exceeds the cost of care. These cases trickle from T02, due to being resource-eligible but income over-scale. Like T 0, the T99 coverage group uses the FAC rules for consideration of income and resources. T99 is similar to L99, which trickles from L98 for the same reasons. MA will not pay for the cost of care in the LTCF because the recipient's available income covers the cost. However, MA will cover other medical services for which the recipient is eligible.

II. CARES Procedures Followed by Medical Assistance Case Managers for MA Eligibility Determinations in the T-Track

The MA CM should screen an applicant in the coverage group for which the applicant is most likely to qualify and which best fits the applicant's circumstances. For example:

- If the recipient is 18-20 years old, the recipient should be screened in T02 which goes up to 21 years old rather than in T05 which goes up to 19 years old.
- If the applicant has countable resources exceeding the medically needy resource standard of \$2,500 for T02, the applicant should be screened in T03-T-05, depending on the applicant's age. Resources are not considered for T03-T05.
- If an A/R is determined ineligible for one T-Track coverage group and either CARES does not trickle or trickles incorrectly, the MA CM should Add-A-Program to screen the A/R in other coverage groups for which the A/R may qualify in the T or L track. The

CAREs denial/closure notice should be suppressed by the MA CM, unless it is determined that the A/R is not eligible for any other LTC coverage group.

AU Screen in T01

A T01 assistance unit (AU) consists of a child or adult who at admission to a LTCF is actively receiving TCA benefits and so is MA community-eligible in F01. MA will pay the facility's cost of care while the child or adult remains eligible for TCA.

- When the CM adds a program to the existing F01 AU, CARES will not display T01 coverage group on the "INCH" screen. Therefore, the CM must call it up. In order to process correctly a T01 Au:
 - The Living Arrangement for this recipient must be coded as "TL" (Temporary LTC Admissions) on the customer's "DEM1" screen for both the F01 and T01 Aus.
 - o All members of the recipient's F01 AU must be coded on the "STAT" screen as a Nonmember (NM) for the recipient's T01 Au.
 - The recipient must be changed on the "STAT" screen to a NM of the F01 Au, which should trigger unscheduled redeterminations for the F01 AU.
- As long as the family remains eligible for TCA (and so is MA eligible as F01), the LTC recipient should remain eligible in T01, unless the recipient ages out of TCA. Then, the recipient's LTC eligibility should be redetermined for the most appropriate coverage group.

AU Screened in T02

This MA coverage group is for an unmarried child under age 21 residing in a LTCF, whose countable resources do not exceed the medically needy standard for a household of one person (\$2,500) and whose countable net income is insufficient to pay the LTC cost of care.

- If the child's resources are within standard and the income is within standard (less than the LTC cost-of-care), the case is eligible for T02 and certified for 12 months, as long as the child's age is under 21.
- If the child is ineligible for T02 because the child's resources are within standard but the income is in excess of the standard (LTC cost-of-care), the case trickles to T99 (spend-down) in a preserved "M" status. As with other MA coverage groups, CARES also evaluates the income. For only the T-track, CARES actually changes the MA coverage group from T02 to T99, indicates that the Au is in spend-down, and gives the Au status Reason Code of "401" to deny for over-scale resources. Therefore, the CM should add

the reason of "301" for over-scale income to the denial/closure notice that CARES generates for T02. CARES denies/closes MA eligibility for a case trickling to T99, and does not allow the CM to update the medical expense screens to authorize a spend-down.

- If the child is ineligible for T02 because the child's resources are over-scale and the income is in excess of the standard (LTC cost of care), CARES denies/closes due over-scaling resources (not also due to over-scale income). Therefore, the case manager should add the reason of "301" for over-scale income to the denial/closure notice that CARES generates.
- If the child is ineligible for T02 because the child's resources are over-scale but the income is within standard for T02, CARES may trickle the T02 Au to T03-T05 depending on the child's age. If not, the MA CM should Add-A-Program to determine eligibility for T03-T05.

AU Screened in T03

For a child under age 1:

- If the income is within 185% FPL, the T03 Au is eligible and certified for 12 months.
- If the child is ineligible for T03 because the child's income is over 185% FPL, but the child's income does not exceed the cost-of-care and the child's resources are within the T02 standard, the CM should Add-A-Program to determine the child's eligibility for T02.
- If the child is ineligible for T03 because the child's income is over 185% FPL, the child's income is greater than the cost-of-care and the child's resources are within the T02 standard, CARES will apply the T02 cost-of-care rules and the AU will go into spend-down (T99). Since CARES gives the AU Status Reason Code as only "401" to deny for over-scale resources, the CM should add the reason of "301" for over-scale income to the notice that CARES generates. CARES denies/closes the eligibility and does not allow the worker to update the medical expense screens to authorize spend-down.
- If the child is ineligible for T03 because the child's resources are also over-scale for the T02 standard, CARES denies/closes due to over-scale resources (Code 401). In the denial notice that CARE generates, the CM should also add the reason of "301" for over-scale income.

AU Screened in T05

For a child who is under age 19 but at least six years old:

• If the income is within 100% FPL, the T05 is eligible and certified for 12 months.

- If the child is ineligible for T05 because the child's income is over 100% FPL, but the child's income does not exceed the cost-of-care and the child's resources are within the T02 standard, the CM should Add-A-Program to determine the child's eligibility for T02.
- If the child is ineligible for T05 because the child's income is over 100% FPL, but the child's income is greater than the cost-of-care and the child's resources are within the T02 standard CARES will apply the T02 cost-of-care rules and the AU will go into spend-down (T99).
- If the child is ineligible for T05 because the child's income is over 100% FPL, but the child's income is greater than the cost-of-care and the child's resources are also over-scale for the T02 standard. CARES denies/closes due to over-scale resource (Code 401). In the denial notice that CARES generates, the CM should also add the reason of "301" for over-scale income.

III. Post-Eligibility Activity

T01 Who Loses TCA Eligibility

When T01 recipient ages out of TCA eligibility, the recipient's LTC eligibility must be redetermined. If the recipient is unmarried and 21 years old, the Eligibility should be redetermined for T02. Otherwise, the recipient's LTC eligibility should be redetermined under the ABD rules for L98.

- If the F01 AU of a T01 child reports a change in countable resources to exceed the TCA categorically needy limit, both AU's will close down (closure reason "401"). CARES will not trickle. Before closing the T01 AU, the CM should Add -A- Program to redetermine eligibility in the T03-T05 coverage group, as appropriate based on the child's age. The T03-T05 coverage groups do not have a resource test.
- If the T01 recipient is an adult whose F01 AU loses TCA eligibility due to over-scale resources, the recipient should be given the opportunity to reduce resources in order to retain MA LTC eligibility in the L98 coverage group. If the resources are not promptly reduced, the T01 case should be closed with proper notice.
- If the F01 AU of a T01 recipient loses TCA eligibility due to over-scale income or another reason, CARES closes both the F01 and T01 AU's. Before closing the T01- T05 coverage group, as appropriate. Also, the T01 recipient should be removed as a non-member of the F-track AU, so the active T-track recipient will not case dual participation for the F-track AU.

T02 Who Becomes Resource- Ineligible

• If the child's <u>resources become over-scale</u> for T02 but the <u>income remains within</u> <u>standard</u> for T03-T05 depending on the child's age, CARES will trickle the AU to appropriate T-track coverage group with respect to the child's age. If the trickling does not occur properly, the MA CM should Add-A-Program to determine eligibility in the most appropriate coverage group.

T03-T05 Who Become Income- Ineligible

• If the <u>resources become over-scale</u> for T02 but the <u>income remains within standard for T03-T05 (based on the child's age) but does not exceed the LRCF's cost-of-care, the case manager should Add-A-Program to determine the child's eligibility for T02.</u>

Child who Age Out of Coverage Group or No Longer Qualifies Due to Marriage

- For a child in T03-T05, the CM should set an alert to trigger an unscheduled redetermination at least 90 days before the child reaches the age limit for the coverage group. The T03 should be tested for T04, the T04 should be tested for T05, and the T05 should be tested for T02. If the child being tested for T04 or T05 has resources that are within the T02 standard and the income is over the standard for T04 or T05, and the T05 (based on the child's age) but does not exceed the LTCF's cost-of-care, the CM should Add-A-Program to determine the child's eligibility for T02.
- If the child who is aging out of T05 is married, the CM must redetermine eligibility under the ABD rules of L98.
- When a child in T02 becomes 20 years old, the CM should set an alert to trigger an unscheduled redetermination at least 90 days before the child reaches 21 years old. The recipient's LTC eligibility should redetermined under the ABD rules for L98.
- When a child in T02 gets married, the CM must redetermine eligibility under the ABD rules of L98.

Unscheduled Redetermination When Recipient is Discharged for LTCF

- When a T-track recipient is discharged from a LTCF an unscheduled redetermination is required. MA eligibility <u>may not be</u> terminated until it is determined that the recipient is not eligible for community MA or MCHP.
- The redetermination procedures for a child discharged from a LTCF are similar to the specific procedures discussed in Chapter 10, Redeterminations Procedures for Children Under the Age of 21 Being Discharged from IMDs, RICAs, or RTCs.
- For Adults discharged to the community, the policies and procedures are addressed on pages 1000-55 and 1000-56 of the MA Eligibility Manual.

- The LDSS must promptly trigger a redetermination of the recipient's eligibility for whatever coverage group fits the recipient's new circumstances.
 - o If the recipient returns to an active TCA household, the LDSS determines if the recipient should be added to the existing TCA AU, and so would become MA eligible in the F01 coverage group.
 - o If the recipient's community household is not eligible for TCA or the F-Track, a child's eligibility may be determined in the P-Track and an adult's eligibility maybe determined in the S-Track.
 - o If a child is discharged into State-sponsored foster care or subsidized adoption, eligibility is determined in the E-Track.
 - If the recipient is discharged into a home and community-based services waiver, eligibility is determined by the DEWS in the H-Track.

NOTE: ALL CASES ACTIVITIES MUST BE FULLY NARRATED IN CARES.

300.5 Pickle Amendment

The Pickle Amendment created a separate category of Medicaid eligibility. Under the Pickle Amendment, an individual who received both SSA and SSI benefits but became ineligible for SSI due to cost-of-living adjustments (COLA) in the SSA benefit will remain eligible for Medicaid if the individual would continue to be eligible for SSI benefits if the COLA increases in the SSA benefits were disregarded. The Pickle Amendment requires that an individual is to be deemed an SSI recipient

Pickle Amendment Eligibility Criteria:

- Terminated from SSI at any time since April 1977 (regardless of reason for termination).
- Currently receiving SSA as an ABD.
- Concurrently received both SSI and SSA at time of termination, The SDX document, SSI termination and SSA award letters, or a combination of these may verify the concurrent receipt of SSA and SSI.
- Currently meets all non-financial requirements for SSI and;
- Would currently be eligible for a SSI payment if the amount of the COLAS received since termination were deducted from the gross income

New Applications:

- ABD applications for MA, including those preserved spend-down status. Must be considered for eligibility under the Pickle Amendment.
- CM determine if an aged, blind, or disabled receipt of SSA and meets the criteria of
 concurrent receipt of SSA and SSI. The applicants are designated as Potentially Pickle
 Eligible (PPE) and the recipients is Pickle Eligible, they will be certified under the Pickle
 Amendment
- For persons who apply under the Pickle Amendment only, but are found ineligible, MN procedures are applied only if it can be determined at the time of application that the person is eligible as medically needy. If it cannot be determined at the time of application, MN procedures are not applied. Pickle Eligibility is denied and the applicant is to be advised to reply time as medically needy. The case would be deemed as "PPE"

Developing the COLA Deduction:

- In order to compute the COLA deduction, the CM must ascertain the date of SSI termination. (sources, SDX, case material or documents submitted by the applicant/recipient)
- The gross amount of the SSA, either at the time SSI was terminated or currently
- (see Attachment A, Calculating worksheet for Pickle Amendment)

Pickle Amendment Certifications and Redeterminations:

- Person determined eligible under the Pickle Amendment will have a twelve month certification period
- Certification begins the month of application
- All active MA cases labeled PPE must be reviewed annually at the time (Annual Review) of the Cost of Living Adjustment (COLA) to determine if the change in the SSI Income and Resource standards will affect their eligibility under the Pickle Amendment.
- For determination of SSI termination, certification begins the month following SSI termination
- For cases determined eligible during the Annual Review, certification begins the month the COLA is received
- PPE cases found eligible at scheduled or unscheduled redeterminations are certified at scheduled or unscheduled redeterminations are certified beginning the month Pickle Eligibility is established

Pickle Amendment Instructions for Use of Notices

DHMH 3803 Notice of Medical Assistance Eligibility for Former Supplemental Security Income Recipients

• This letter is used to notify all persons who are found eligible under the Pickle Amendment. Check the appropriate space in the heading of the letter, "Application" or "Redetermination", and the corresponding space in the body of the letter. Complete the body with appropriate dates

DHMH 4214 Notice of Ineligibility for Medical Assistance (Pickle Amendment Applicant)

This letter is used to notify those persons who apply for Medical Assistance under the
Pickle Amendment only and are found ineligible. These are persons who are not current
Medical Assistance recipients and who file an application in response to the individual or
public notice of potential eligibility.

DHMH 4215 Notice of Ineligibility under the Pickle Amendment (Current Recipients)

This letter is used to notify current Medical Assistance recipients that they have been
considered for Pickle eligibility but have been found ineligible under this provision.
These are current recipients who have had a Pickle determination made as a result of the
onetime review or annual review. This letter does not affect the person's current
eligibility as medically needy.

DHMH 4226 Notice of Termination of Medical Assistance (Pickle Amendment)

• This letter is used to notify persons who were previously eligible under the Pickle Amendment that their eligibility has been redetermined and they are no longer eligible. Excess income and/or resource amounts are based on the medically needy standards that have been applied after the person was determined no longer eligible under the Pickle Amendment. If Pickle eligibility was lost due to a cessation of disability or blindness the person would be considered under MASO regulations and income is to be considered for a 3 month period. Persons who lose Pickle eligibility for other reasons will have income considered for 6 months under the ABD regulation. Circle the appropriate period

DHMH 1159F

Worksheet- Pickle Eligibility

A person is eligible under the Pickle Amendment if <u>all</u> factors are met.

If the response to any statement is "No", do not continue worksheet; the person is determined ineligible under the Pickle Amendment.

		Yes	No
I. Terminated from SSI after A Received both SSI and SSE Currently receives Social S	prior to termination		
II. Aged, Blind or Disabled Citizenship, residency, etc.			
III. Resources of \$equal to SSI standard of	less than or		
IV. Income Calculation: Gross Monthly Income COLA Deduction Net Monthly Income SSI standard	\$ \$ <u>less</u> than \$		

DHMH 1159G

Worksheet- COLA Deduction

(Pickle Amendment)

Method A

Locate appropriate line based on SSI termination date.

Enter the amount of Social Security Benefit at time of SSI termination in Column 1.

Multiply by COLA factor, Column II, enter Product in Column III.

Enter the amount from Column III on the next line, Column I.

Continue until current benefit is reached.

	I		II		III
SSI Terminated Before:	Previous Benefit	COLA	Factor	Increas	sed Benefit
July, 1977		X	1.059	=	
July, 1978	>	ĸ	1.065	=	
July, 1979	>	ĸ	1.099	=	
July, 1980		X	1.143	=	
July, 1981		ĸ	1.112	=	
July, 1982		K	1.074	=	
Jan., 1984		X	1.035	=	
Jan., 1985		X	1.035	=	
	X			=	
	X			=	
	X			=	
Current SSB	\$	S			
Benefit at SSI Termination	n §	S			
COLA Deduction	\$	S			

Method B

Enter current Social Security Benefit on Line I, Column I.

Divide by COLA factor, Column II, enter result in Column III.

Enter the amount from Column III on the next line, Column I.

Continue until benefit at the time of SSI termination is reached.

SSI Terminated	I Most			II	III
Before:	Current Benefi	t	COLA F	actor	Previous Benefit
		+		=	
		+		=	
		+		=	
Jan., 1985		+	1.035	=	
Jan. 1984		+	1.035	=	
July, 1982		+	1.074	=	
July, 1981		+	1.112	=	
July, 1980		+	1.143	=	
July, 1979		+	1.099	=	
July, 1978		+	1.065	=	
July, 1977		+	1.059	=.	
Current SSB		\$			
Benefit at SSI Termination	n				
COLA Deduction		\$			

DHMH 3802

MARYLAND MEDICAL ASSISTANCE PROGRAM NOTICE OF MEDICAL ASSISTANCE ELIGIBILITY FOR FORMER SUPPLEMENTAL SECURITY INCOME RECIPIENTS

(Pickle Amendment)

	(Tickic Affic	nument)
	Application	Redetermination
		Date of Notice:
		Case Numbers:
Dea	r:	
Thi	s is to notify you that:	
	eligible effective Within a short time, you will receive a red and	white plastic card. You must show your Medical emembership cards for all health care services you have
	·	eligibility you have been determined eligible effective
be r	ger eligible. You will be required to reestablish	your eligibility at least once every 12 months. You will re the expiration of your current eligibility period. The
proj cha	changes in your circumstances or your family's perty, stocks, bonds, marital status, living arrang	ng increases you receive, you must notify this agency of circumstances such as employment, income, savings, ement, address and telephone number. Any of these ort any changes in your situation within 10 working
elig		disagree with any decisions relating to your period of for requesting a hearing are in the back of this letter.
		Sincerely,
		Case Manager
		DEPARTMENT OF SOCIAL SERVICES
		TELEPHONE NUMBER

Summary of Procedures for Hearings

If you are dissatisfied with any decision relating to your eligibility period or service coverage, you have the right to appeal that decision to the Department of Health and Mental Hygiene. You may obtain the necessary forms from the local department and if you wish, someone there will assist you in filing an appeal.

Your appeal must be filed within 90 days from the notice date on the other side of this letter. The hearing will be scheduled by the Department of Health and Mental Hygiene, at a place and time that is convenient for you. You will be expected to be present; or if for some reason you cannot be present, you must notify the Department of the identity of the person who will attend in your place. You may represent yourself or, if you wish, you may be represented by legal counsel or by a relative, friend, or other person, although it is not required that someone else represent you. You may bring any witnesses you desire to help you establish pertinent facts and explain your circumstances. A reasonable number of persons of the general public may be admitted to the hearing if you desire this. At least six (6) days before the hearing, the local department will send you a letter containing pertinent information, including the specific reason for your wanting to appeal.

DHMH 4214

MARYLAND MEDICAL ASSISTANCE PROGRAM NOTICE OF INELIGIBILITY FOR MEDICAL ASSISTANCE

(Pickle Amendment- Applicant)

	Date of Notice: Case Number:
Dear	:
On requires that yo	you applied for Medical Assistance under the Pickle Amendment. This ou meet certain criteria and that your income and resources be compared to SSI standards by you that you have been determined ineligible for the reason(s) checked below:
	You are not currently receiving Social Security benefits due to age, blindness or disability.
	You were not terminated from SSI since April 1977.
	You did not receive both Social Security and SSI at the time of SSI termination.
	You do not meet the non-financial requirements for SSI. (Specify)
	You failed to appear at the Local Department for the required interview.
	You did not provide the information/verifications required to determine your eligibility.
	Your total countable resources of \$ exceed the applicable SSI resource standard by \$
	Your income exceeds the applicable SSI payment standard by \$ monthly. Your Social Security cost-of-living increases have been deducted in arriving at this amount.
	Other (Specify)
	This decision is based on COMAR 10.09.24.03B (3). If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are on the back of this letter. You also have the right to reapply and request that your eligibility be tested under the medically needy provisions.
	Sincerely,
	Case Manager
	Department of Social Services
	Telephone Number

Summary of Procedures for Hearing

If you believe the decision of the Local Department of Social Services is incorrect, you have the right to appeal that decision to the Department of Health and Mental Hygiene. You may obtain the necessary forms from the local department and if you wish, someone there will assist you in filing an appeal. Your appeal must be filed within 90 days from the date on the other side of this letter.

The hearing will be scheduled by the Department of Health and Mental Hygiene at a place and time that is convenient to you. You will be expected to be present or, if for some reason you cannot be present, you must notify the Department of the identity of the person who will attend in your place. Your may represent yourself, or, if you wish, you may be represented by legal counsel, a relative, friend, or other person, although it is not required that someone else represent you. You may bring any witness you desire to help you establish <u>facts pertinent to your circumstances</u>. At least six (6) days before the hearing, the local department will send you a letter containing pertinent information, including the specific action or inaction that you are appealing.

The Hearings Officer will decide whether the action of the local department was correct in its interpretation of the law and regulations. This decision will be sent to you as soon as possible, but not later than 90 days after the receipt of your request for a hearing, unless there is a delay because you request that the hearing be postponed.

DHMH 4215

MARYLAND MEDICAL ASSISTANCE PROGRAM NOTICE OF INELIGIBILITY UNDER THE PICKLE AMENDMENT (Current Recipients)

	Date of Notice: Case Number:
Dear	
eligible under the F income and resourc	advise you that your Medical Assistance case has been reviewed to determine if you are Pickle Amendment. That amendment requires that you meet certain criteria and that your ces be compared to the appropriate SSI standards. This is to notify you that you have neligible under that amendment for the reason(s) checked below:
	You are not currently receiving Social Security benefits due to age, blindness or disability.
	You were not terminated from SSI since April 1977.
	You did not receive both Social Security and SSI at the time of SSI termination.
	You do not meet the non-financial requirements for SSI. Specify)
	You did not provide the information/verifications required to determine your eligibility.
	Your total countable resources of \$ exceed the applicable SSI resource standard by \$
Y	Your income exceeds the applicable SSI payment standard by \$ monthly. Your Social Security cost-of-living increases have been deducted in arriving at this amount.
	Other (Specify)
recipient of Medic	sion is based on COMAR 10.09.24.03B (3). Since you are a current real Assistance as a result of an earlier application, your eligibility will continue for the rur card unless you are notified otherwise.
You are s eligibility.	still responsible for reporting changes in your situation which may affect your current
	lieve this decision is incorrect, you have the right to request a hearing. The procedures aring are on the back of this letter. You continue to have the right to reapply when your expires.
,	Sincerely,
	Case Manager
	Department of Social Services
	Telephone Number

Summary of Procedures for Hearing

If you believe the decision of the Local Department of Social Services is incorrect, you have the right to appeal that decision to the Department of Health and Mental Hygiene. You may obtain the necessary forms from the local department and if you wish, someone there will assist you in filing an appeal. Your appeal must be filed within 90 days from the date on the other side of this letter.

The hearing will be scheduled by the Department of Health and Mental Hygiene at a place and time that is convenient to you. You will be expected to be present or, if for some reason you cannot be present, you must notify the Department of the identity of the person who will attend in your place. You may represent yourself or, if you wish, you may be represented by legal counsel, a relative, friend, or other person, although it is not required that someone else represent you. You may bring any witness you desire to help you establish the facts pertinent to your circumstances. At least six (6) days before the hearing, the local department will send you a letter containing pertinent information, including the specific action or inaction that you are appealing.

The Hearings Officer will decide whether the action of the local department was correct in its interpretation of the law and regulations. This decision will be sent to you as soon as possible, but no later than 90 days after the recipe of your request for a hearing, unless there is a delay because you request that the hearing be postponed.

DHMH 4226

MARYLAND MEDICAL ASSISTANCE PROGRAM NOTICE OF TERMINATION OF MEDICAL ASSISTANCE

(Former Pickle Amendment Recipient)

	Date of Notice: Case Number:				
Dear	;				
have de below:	This is to notify you that based on a recent review of your eligibility for Medical Assistance; we termined that you are no longer eligible effective for the reason(s) checked				
A. Fin	ancial:				
	Your countable income has increased from \$ to This results in excess income of \$ monthly or \$ for a (circle one) 3 month 6 month period based on the applicable medically needy income level. This decision is based on COMAR 10.09.24.09C. You may become eligible again in the future if you receive medical expenses which equal or exceed the excess amount; however, you must reapply so that an accurate determination can be made.				
	Your resources exceed the applicable medically needy resource level by \$ This decision is based on COMAR 10.09.24.09C(3). The excess amount must be used to pay for medical or necessary living expenses.				
B. No	n-Financial:				
	You did not submit a completed and signed application for a redetermination of your eligibility.				
	You failed to appear at the Local Department for the required interview.				
	You did not provide the information/verifications required to determine continued eligibility.				
	Other- Specify:				
	This decision is based on COMAR 10.09.24				
	If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are on the back of this letter. You also have the right to reapply at any time.				
	Sincerely,				
	Case Manager				
	Department of Social Services				
	Telephone Number				

Summary of Procedures for Hearing

If you are dissatisfied with the decision of the Local Department of Social Services, you have the right to appeal that decision to the Department of Health and Mental Hygiene. You may obtain the necessary forms from the local department and if you wish, someone there will assist you in filing an appeal.

Your appeal must be filed within 90 days from the notice date on the other side of this letter. If you request a hearing within 10 days of the date of the cancellation, your Medical Assistance benefits will continue until a decision is issued on your case. However, if you receive extended benefits pending a decision on your appeal and the hearing officer decides that the decision of the Local Department of Social Services was correct, you will be required to pay back the amount the Department paid for medical services you received during the appeal process. This will not be required if it is determined that your request for a hearing resulted from a bona fide belief that the decision of the Local Department of Social Services was in error.

The appeal hearing will be scheduled by the Department of Health and Mental Hygiene at a place and time that is convenient for you. You will be expected to be present, or, if for some reason you cannot be present, you must notify the Department of the identity of the person who will attend in your place. You may represent yourself, or, if you wish, you may be represented by legal counsel or by a relative, friend, or other person, although it is not required that someone else represent you. You may bring any witness you desire to help you establish pertinent facts and explain your circumstances. A reasonable number of persons of the general public may be admitted to the hearing if you desire this. At least six (6) days before the hearing, the local department will send you a letter containing pertinent information, including the specific reason for your wanting to appeal. The Hearing Officer will decide whether or not the action of the local department was correct in its interpretation of the law and regulations. This decision will be sent to you as soon as possible, but not later than 90 days after the receipt of your request for a hearing, unless there is a delay because you request that the hearing be postponed.

MARYLAND MEDICAL ASSISTANCE PROGRAM

IMPORTANT NOTICE ABOUT YOUR MEDICAID ELIGIBILITY

IF YOU ONCE RECEIVED SSI BENEFITS YOU SHOULD READ THIS IMPORTANT NOTICE ABOUT YOUR ELIGIBILITY FOR MEDICAID BENEFITS. (If you never received SSI or if you now receive SSI or TCA or if you live in a Long-Term-Care facility, this notice will not apply to you.)

A federal law called the Pickle Amendment applies to people who meet three tests:

- 1. They now receive Social Security benefits (a green check); and
- 2. They used to receive SSI benefits (a gold check) but don't receive them now; and
- 3. They received <u>both</u> a Social Security <u>and</u> an SSI check in the same month, in at least one month since April, 1977.

IF YOU MEET <u>ALL</u> THREE OF THESE TESTS, YOU MAY BE ELIGIBLE TO RECEIVE THE SAME MEDICAID BENEFITS YOU RECEIVED WHEN YOU WERE GETTING SSI.

To find out if you are eligible, you (or someone on your behalf) should contact your local Department of Social Services. For more information, call the Department of Social Services in your area. Phone numbers and addresses are listed on the back of this notice.

PLEASE NOTE THAT TO APPLY FOR MEDICAID UNDER THE PICKLE AMENDMENT, YOU OR YOUR REPRESENTATIVE MUST GO TO YOUR LOCAL DEPARTMENT OF SOCIAL SERVICES. TAKE THIS NOTICE WITH YOU WHEN YOU GO.

MARYLAND MEDICAL ASSISTANCE PROGRAM NOTICE OF POTENTIAL RETROACTIVE ELIGIBILITY UNDER THE PICKLE AMENDMENT

	Date:
	Case Number:
Dear:	
retroactive coverage beginning November	ance case indicates that you may be eligible for et 1, 1984. This means that you may be eligible for expenses incurred before you applied under the Pickle his retroactive coverage you must:
- Have incurred medical expen November 1, 1984 through _	nses coverable under the Program during the period ;
- Complete the enclosed applic Services;	cation and return it to the local Department of Social
- Appear for a face-to-face inte	erview; and
- Meet all eligibility requireme	ents during the retroactive period.
	s during the period specified above, and you wish to hese expenses, complete the enclosed application and s notice.
A decision not to apply for retroa You will remain eligible for Medical Ass	active coverage will <u>not</u> affect your current eligibility. istance until you are notified otherwise.
	Sincerely,
	Case Manager
	Department of Social Services
	Telephone Number

MARYLAND MEDICAL ASSISTANCE PROGRAM NOTICE OF RETROACTIVE ELIGIBILITY UNDER THE PICKLE AMENDMENT

Date:		
Case Number:		
Dear:		
	or retroactive Medical Assistance filed on through	
health insurance membership cards for all unpaid hea	plastic card. You must show your Medical Assistance card lth care services you received during this period. If you have already paid for medical care received during this perimbursement for their expenses.	ave already paid
	Since you are a current recipient of Medical Assistance as the dates shown on your current card unless you are notified	
You are still responsible for reporting changes in you	r situation which may affect your current eligibility.	
You have the right to request a hearing if you disagree provided. The procedures for requesting a hearing are	e with any decisions relating to your period of eligibility of the back of this letter.	or the services
	Sincerely.	
	Case Manager	
	Department of Social Services	
	Telephone Number	

Summary of Procedures for Hearings

If you are dissatisfied with any decision relating to your eligibility period or service coverage, you have the right to appeal that decision to the Department of Health and Mental Hygiene. You may obtain the necessary forms from the local department and, if you wish, someone there will assist you in filing an appeal.

Your appeal must be filed within 90 days from the notice date on the other of side this letter. The hearing will be scheduled by the Department of Health and Mental Hygiene at a place and at a time this convenient for you. You will be expected to be present at the hearing. If, for some reason, you cannot be present, you must notify the Department of the identity of the person who will attend in your place. You may represent yourself or, if you wish, you may be represented by legal counsel or by a relative, friend, or other person. It is not required thought that someone else represents you. You may bring any witnesses you desire to help you establish pertinent facts and explain your circumstances. A reasonable number of persons of the general public maybe admitted to the hearing if you desire. At least six (6) days before the hearing, the local department will send you a letter containing pertinent information, including the specific reason for wanting to appeal.

MARYLAND MEDICAL ASSISTANCE PROGRAM

Letter of Instructions on Reimbursement/Payment For Medical Expenses under the Pickle Amendment

Date of Letter:
Case Number:
Dear:
The attached letter indicates that you have been found eligible for Medicaid for the period/through _/through _/ If during this period you made payment for medical services, you may be reimbursed if you provide written naterials showing the type of service received, by whom it was provided, the amount charged and the amount you paid. This information should be obtained from the provider of the services, e.g., your physician, hospital, pharmacy, and should be sent to
Division of Eligibility Services Medical Assistance Policy 01 West Preston Street Baltimore, Maryland 21201
f during this period for which you were eligible for Medicaid, you received services for which you did not make payment, pleas dvise the provider of services that he should submit a claim to Medicaid in the usual fashion.
all claims and supporting materials must be received no later than 45 days from the date of this letter. Payment will be made only or services covered under the Medicaid State Plan in effect at the time the services were provided and only in the amount llowable under the State Plan.
f you have questions on how to seek reimbursement for yourself or payment for the provider of services, please call 410-767-463. Please indicate that you calling concerning reimbursement for medical services under the Pickle Amendment.
incerely,
Case Manager
Department of Social Services
Celephone Number

MARYLAND MEDICAL ASSISTANCE PROGRAM NOTICE OF INELIGIBILITY FOR RETROACTIVE COVERAGE UNDER THE PICKLE AMENDMENT

Case Number:	
Dear	:
This is to notify y	ou that based on your application for retroactive Medical Assistance filed on
You have been de	etermined ineligible for the retroactive period through
You ha	ve been determined ineligible for that period for the reason(s) checked below:
	You were not receiving Social Security benefits due to age, blindness or disability during that period
	You did not meet the non-financial requirements for SSI during that period. (Specify)
	You did not provide the information/verifications required to determine your eligibility for that period.
	Your total countable resources of \$ exceeded the applicable SSI resources standard by \$
	Your income exceeded the applicable standard by \$ monthly.
	Other (Specify)
of an earlier appli You are If you b	cision is based on COMAR 10.09.24.03B (3). Since you are a current recipient of Medical Assistance as a resultation, your eligibility will continue for the dates shown on you current card unless you are notified otherwise. The estill responsible for reporting changes in your situation which may affect your current eligibility. The procedures for requesting a hearing this letter. You continue to have the right to reapply when your current eligibility expires.
Sincerely,	
Case Manager	
Department of So	ocial Services
Telephone Numb	<u> </u>

Summary of Procedures for Hearings

If you are dissatisfied with any decision relating to your eligibility period or service coverage, you have the right to appeal that decision to the Department of Health and Mental Hygiene. You may obtain the necessary forms from the local department and, if you wish, someone there will assist you in filing an appeal.

Your appeal must be filed within 90 days from the notice date on the other of side this letter. The hearing will be scheduled by the Department of Health and Mental Hygiene at a place and at a time this convenient for you. You will be expected to be present at the hearing. If, for some reason, you cannot be present, you must notify the Department of the identity of the person who will attend in your place. You may represent yourself or, if you wish, you may be represented by legal counsel or by a relative, friend, or other person. It is not required thought that someone else represents you. You may bring any witnesses you desire to help you establish pertinent facts and explain your circumstances. A reasonable number of persons of the general public maybe admitted to the hearing if you desire. At least six (6) days before the hearing, the local department will send you a letter containing pertinent information, including the specific reason for wanting to appeal.

Worksheet - Pickle Eligibility

A person is eligible under the Pickle Amendment if all factors are met.

If the response to any statement is "No", do not continue worksheet; the person is determined ineligible under the Pickle Amendment.

			Yes	No
I.	Terminated from SSI after April, 1977			
	Received both SSI and SSB prior to termination			
	Currently receives Social Security Benefits			
II.	Aged, Blind or Disabled			
	Citizenship, residency, etc.			
III.	Resources of \$less than or equal to SSI standard of \$			
IV.	Income Calculation:			
	Gross Monthly Income \$			
	COLA Deduction			
	Net Monthly Income \$ <u>1</u>	less than		
	SSI standard \$			

Worksheet- COLA Deduction

(Pickle Amendment)

Method A

Locate appropriate line based on SSI termination date.

Enter the amount of Social Security Benefit at the time of SSI termination in Column I.

Multiply by COLA factor, Column II, enter Product in Column III.

Enter the amount form Column III on the next line, Column I.

Continue until current benefit is reached.

SSI Terminated Before:	I. Previous Benefit	II. COLA Factor		III. Increased Benefit
July, 1977	×	1.059	=	
July, 1978	×	1.065	=	
July, 1979	×	1.099	=	
July, 1980	×	1.143	=	
July, 1981	×	1.112	=	
July, 1982	×	1.074	=	
Jan., 1984	×	1.035	=	
Jan., 1985	×	1.035	=	
	×		=	
	×		=	
	×		=	
			-	
Current SSB	\$ <u></u>			
Benefit of SSI Tern	nination			
COLA Deduction	\$			

DHMH 1159G

Method B

Enter current Social Security Benefit on Line I, Column 1. Divide by COLA factor, Column II, enter result in Column III. Enter the amount from Column III on the next line, Column I. Continue until benefit at the time of SSI termination is reached.

	I.		II.		III.	
SSI Terminated Before:	Most		COLA Fac	tor	Previous Benefit	
		+	-	_ =		_
		+		_ =		_
		+		_ =		_
Jan., 1985		+	1.035	=		_
Jan., 1984		+	1.035	=		_
July, 1982		+	1.074	=		_
July, 1981		+	1.112	=		_
July, 1980		+	1.143	=		_
July, 1979		+	1.099	=		_
July, 1978		+	1.065	=		_
July, 1977		+	1.059	=		_
Current SSB		\$				
Benefit at SSI Termina	ation					
COLA Deduction		\$				

Pickle Amendment Instructions for Use of Notices

1. DHMH 3802 Notice of Medical Assistance Eligibility for Former Supplemental Security Income Recipients

This letter is used to notify all persons who found eligible under the Pickle Amendment. Check the appropriate space in the heading of the letter, "Application" or "Redetermination", and the corresponding space in the body of the letter, "Application" or Redetermination", and the corresponding space in the body of the letter. Complete the body with appropriate dates.

For new applicants (non-recipients) check the first black in the heading and the body of the letter. For recipients found eligible as a result of the one-time review, annual review, scheduled or unscheduled redetermination, check the second black in the heading and the body of the letter.

2. DHMH 4214 Notice of Ineligibility for Medical Assistance (Pickle Amendment Applicant)

This letter is used to notify those persons who apply for medical assistance under the Pickle Amendment only and are found ineligible. These are persons who are not current Medical Assistance recipients and who file an application in response to the individual or public notice of potential eligibility.

3. DHMH 4215 Notice of Ineligibility Under the Pickle Amendment (Current Recipients)

This letter is used to notify current Medical Assistance recipients that they have been considered for Pickle eligibility but have been found ineligible under this provision. These are current recipients who have had a Pickle determination made as a result of the one-time review or annual review. This letter does not affect the person's current eligibility as medically needy.

4. DHMH Notice of Termination of Medical Assistance (Pickle Amendment)

This letter is used to notify persons who were previously eligible under the Pickle Amendment that their eligibility has been redetermined and they are no longer eligible. Excess income and/or resource amount are based on the medically needy standards that have been applied after the person was determined no longer eligible under the Pickle Amendment. If Pickle eligibility was lost due to a cessation of disability or blindness the person would be considered under MASO regulations and income is to be considered for a 3 month period. Persons who lose Pickle eligibility for other reasons will have income considered for 6 months under the ABD regulations. Circle the appropriate period.

A Quick and Easy Method of Screening for Medicaid Eligibility under the Pickle Amendment

Screening for Medicaid eligibility under the Pickle Amendment is quick and simple. The screening process will eliminate the great majority of those who are not eligible without the necessity of performing any mathematical calculations. For those who survive the initial screening and for whom mathematical calculations are required, the table below provides a simple formula for performing the necessary calculations.

The Screening Process is as Follows:

Step 1: Does the applicant receive Social Security benefits? If the answer is no, then the person cannot be Pickle eligible. If the answer is yes, go on to the next step.

Step 2: After April 1977, did the applicant receive SSI? If the answer is no, the person cannot be Pickle eligible. If the answer is "yes", go on to step 3.

Step 3: CM should ask applicant, "When was the last month you received SSI?" Once month is provided CM should then verify State Verification and Exchange System (SVES) for ending date.

Step 4: Look up the month in which the person last received SSI in the following table. Find the percentage that applies to that month. Multiply the present amount of the applicants (and/or spouse's) Social Security benefits by the applicable percentage.

Example

Mrs. Irma Gherkin received both Social Security and SSI checks in 1976-78. However, her SSI was terminated in March 1978 because she started receiving a private pension that, added to her Social Security benefits, raised her income to an amount above the 1978 SSI income limits. There have been gradual increases in her income since 1978. She now receives a Social Security benefit of \$1,229 per month, which happens to be the average monthly benefit for retired workers. Her private pension is \$275 a month, giving her a total of \$1,504 monthly. In 2012, the income limit for SSI (taking into account a \$20 general income disregard) is \$718 for an individual. Thus, Mrs. Gherkin's income is over twice the SSI income limit, which her state has adopted as the Medicaid limit for persons who are aged, blind or disabled. You screen Mrs. Gherkin for Pickle eligibility as outlined above. Determining that the last month in which she received both Social Security and SSI was March 1978, you look up that time period in the

Following table and find the corresponding reduction factor (.273).

- Multiply Mrs. Gherkin's current Social Security benefit of \$1,229 by that factor, to determine her current countable "Pickle" income.
- \$1229 multiplied by .273 = \$335 ("Pickled" Social Security income, rounded downward) \$335 countable Social Security income + \$275 private pension = \$610 total countable "Pickle" income.
- Since \$610 is less than the current SSI income limit (including the standard \$20 disregard) of \$718,
- Mrs.Gherkin is eligible for Medicaid, even though she is ineligible for SSI.

Attachment A

Reduction Factors for Calculating Medicaid Eligibility under the Pickle Amendment During 2012

If SSI was terminated during this period:	Multiply 2012 Social Security income by	If SS was terminated during this period:	Multiply 2012 Social Security income by:	If SSI was terminated during this period:	Multiply 2012 Social Security income by:
May- June 1977	.257	Jan.1988-Dec.1988	.508	Jan.1999-Dec. 1999	.717
July 1977- June 1978	.273	Jan.1989-Dec.1989	.528	Jan.2000-Dec.2000	.735
July 1978- June 1979	.290	Jan.1990-Dec.1990	.553	Jan. 2001-Dec.2001	.760
July 1979- June 1980	.319	Jan.1991-Dec.1991	.583	Jan.2002-Dec. 2002	.780
July 1980- June 1981	.365	Jan.1992-Dec.1992	.604	Jan.2003-Dec.2003	.791
July 1981- June 1982	.405	Jan.1993-Dec.1993	.622	Jan.2004-Dec.2004	.808
July 1982- Dec 1983	.435	Jan.1994-Dec.1994	.638	Jan.2005-Dec.2005	.829
July 1984- Dec 1984	.451	Jan.1995-Dec.1995	.656	Jan.2006-Dec.2006	.863
July 1985- Dec 1985	.466	Jan.1996-Dec.1996	.673	Jan.2007-Dec.2007	.892
July 1986- Dec 1986	.481	Jan.1997-Dec.1997	.693	Jan.2008-Dec.2008	.912
July 1987- Dec 1987	.487	Jan.1998-Dec.1998	.707	Jan.2009-Dec.20011	.965

i. Due to Social Security's rounding rules, the adjustment factors in the table produce an approximate, rather than exact, figure. Because a discrepancy of one cent may mean the difference between Medicaid eligibility as a Pickle case and no meaningful access to health care, advocates should obtain exact information from the Social Security Administration if the figure produced by the screening method results in a determination that the client is over the eligibility limit by a small amount (i.e., \$20 or less).

Attachment B

Social Security Cost of Living Adjustments

Date of Increase	Increase	COLA Factor
Jan., 1985	3.5%	1.035
Jan., 1986	3.1%	1.031
Jan., 1987	1.3%	1.013
Jan., 1988	4.2%	1.042
Jan., 1989	4.0%	1.040
Jan., 1990	4.7%	1.047
Jan., 1991	5.4%	1.054
Jan., 1992	3.7%	1.037
Jan., 1993	3.0%	1.030
Jan., 1994	2.6%	1.026
Jan., 1995	2.8%	1.028
Jan., 1996	2.6%	1.026
Jan., 1997	2.9%	1.029
Jan., 1998	2.1%	1.021
Jan., 1999	1.3%	1/013
Jan., 2000	2.4%	1.024
Jan., 2001	3.5%	1.035
Jan., 2002	2.6%	1.026
Jan., 2003	1.4%	1.014
Jan., 2004	2.1%	1.021
Jan., 2005	2.7%	1.027
Jan., 2006	4.1%	1.041
Jan., 2007	3.3%	1.033
Jan., 2008	2.3%	1.023
Jan., 2009	5.8%	1.058
Jan., 2011	3.6%	1.036

ii. Due to the recession, the cost of living did not increase for two years after 2008. Therefore, there was no Social Security COLA in 2010 or 2011. The cost of living increased by 3.6% in 2011, causing SSI income limits to increase by that amount in January 2012. Because of this history, the Pickle reduction factor is the same for individuals who lost SSI in 2009-2011.

Attachment C

SSI Resource Standards

Effective	Individual	Couple
1/1/1974	\$1,500.00	\$2,250.00
1/1/1985	\$1,600.00	\$1,450.00
1/1/1986	\$1,700.00	\$2,550.00
1/1/1987	\$1,800.00	\$2,700.00
1/1/1988	\$1,900.00	\$2,850.00
1/1/1989- 1/1/2012	\$2,000.00	\$3,000.00

Note: The SSI Resource Standard limits have not changed since 1989.

Section 300 Frequently Asked Questions and Answers Coverage Groups

- 1. What is a coverage group? A <u>coverage group</u> is a group of persons who must satisfy a common set of requirements for determining eligibility for Medical Assistance
- 2. What is a "Track" and what are some of the most common ones? A track is a group of related coverage groups. Currently there are 11 tracks. The same eligibility rules are used for all coverage groups in the same track.
 - Children placed in foster care or subsidized adoptions (**E-Track**)
 - Low income pregnant women and children in the Maryland Children's Health Program (MCHP) (P-Track)
 - Uninsured children under the age of 19 whose income is above 200% but below 300% of the Federal Poverty Level. (**D-Track**)
 - Aged, blind, or disabled individuals (ABD) (**S-Track**)
 - Refugees (G-Track)
 - Family and Children (FAC) –F-Track
 - Aliens (**X02**)
 - Long term care (LTC) cases have their own tracks,
 - o ABD individuals (L-Track)
 - Children and Temporary Cash Assistance (TCA) adults and Family Long Term Care (T-Track)
- 3. What is the Pickle Amendment?

Under the Pickle Amendment the program establishes Medical Assistance eligibility for certain former SSI recipients who currently receive Social Security benefits. These are the persons who would still be eligible for SSU payments if their income were reduced by the total amount of all Social Security Cost of Living Adjustments (COLAS) received since their SSI was terminated. The person would be deemed as a SSI recipient.

4. Can an ineligible or illegal pregnant woman apply for Labor and deliver only service prior to birth?

Yes, the ineligible or illegal pregnant immigrant can now file an application with the (LDSS) and LHD prior to the birth of a child.

5. Is it possible to be dually eligible for Medicare and MA services?

Yes, a recipient in QMB Buy-in only program, that meets spend-down is considered dual eligible.